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PUBLIC HEARING

BY

STUDY COMMITTEE ON AGING

September 21, 1979

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Columbia, September 21, 1979

Senator Hyman Rubin, Chairman

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A Public Hearing was held by the Joint Legislative Study Committee on Aging in the Senate Chamber of the State House, in Columbia, South Carolina, on Friday, September 21. The Hearing convened at 10:30 A.M.

Senator Hyman Rubin, Chairman of the Committee, called the Hearing to order and in behalf of the Committee welcomed the guests. In his opening remarks, he explained that this Public Hearing is held each year and has proven to be of great value to the Committee which is now in its tenth year of working on the problems of the elderly. These Hearings serve to provide the input, guidance and suggestions which help the Committee to formulate the program of action--not only legislative action with respect to bills to be introduced, but the ways and means whereby citizens can be encouraged to become concerned with the problems of senior citizens and to add their voluntary participation. It has been said that senior citizens are the fastest growing minority group in this country. Minority groups have to fight for their survival, their advancement and their welfare. He said that we, in our Judeo-Christian society, recognize the moral imperative of concerning ourselves with older people, to make their lives more comfortable, more dignified and more secure.

He enumerated the Committee's accomplishments of the past session:

Written into the Appropriation Bill an increase in the Homestead Tax Exemption to $15,000 effective in 1981.

A new pre-retirement program was created to help train people to get ready for retirement. Mr. Purvis Collins, Director of the State Retirement System will handle this.

The Medicaid Income Limitation ("cap") was raised to $624.60. Just a few years ago it was $350.

The Commission on Aging received an increase from $425,000 to $500,000 for its councils on aging.

Two percent were added to cost-of-living benefits for retirees, which raised it from 4 to 6 percent.

The Committee will continue to support the pilot project in Spartanburg, Union and Cherokee counties, designated as the Community Long Term Care Project, which shows how much can be accomplished through cooperative efforts in the way of home health services. This will be the way we have to go in the future.

Legislation was passed, providing for free admission to most of the State Park facilities.

The Committee will continue to address itself and formulate objectives which can be accomplished.

He read a paragraph from the Annual Report to the Governor and Members of the General Assembly, which succinctly states the Committee's object:

"The object of the Committee has been not only to provide material assistance, but also to develop through education a climate of respect for older people and a momentum for activity from all quarters, governmental and the private sector."

The conclusion of the Annual Report states that "progress begets progress, and we are confident that many other gains can be achieved for our elderly so that to the end the older years can be years of comfort, prosperity and happiness."

Senator Rubin said that the Committee will continue with those objectives.

The members of the Committee were introduced. Present were: Senator Dewey Wise, Charleston, Representatives Pat Harris, Vice Chairman, Anderson, Parker Evatt, Columbia, and Hudson Barksdale, Spartanburg. Senator John Waller was unable to attend. The two new gubernatorial appointees were present. They were: Mrs. Gloria H. Trowell, Varnville, and Reverend M. L. (Jack) Meadors, Jr., Anderson. Dr. Julian Parrish, who was reappointed by the Governor, also attended the Hearing. Staff present were: Mrs. Keller H. Bumgardner, Director of Research and Administration, Study Committee on Aging, and Mrs. Rose Mary Smith, Administrative Assistant, Senate Medical Affairs Committee.

One bit of sad information which Senator Rubin announced was that Mrs. Marguerite King, Assistant State Director, American Association for Retired Persons, passed away Thursday night. She was in Columbia to attend a meeting of the NRTA-AARP Joint Legislative Committee and had planned to attend this Hearing today. "We are deeply saddened by this," said Senator Rubin, "but such are the uncertainties of this existence."

With these opening remarks, the floor was opened for the first speaker.

William V. Bradley
State Ombudsman
Office of the Governor
Fourth Floor, Edgar A. Brown Building
Columbia, South Carolina 29201

Mr. Bradley's Statement is on the following pages. There were no questions asked by members of the Committee. Senator Rubin thanked Mr. Bradley for his comments and commended him on working closely with the Committee. He assured him that the Committee will do its best to move along in the areas which Mr. Bradley had listed in his statement.

Senator Rubin and members of the commitee: I appreciate the opportunity to discuss with you some of my areas of concern as they affect the aged citizens of our state. I would also like to give a word of praise to this committee for many battles each of you has fought on behalf of older people.

When I talk with the elderly of our state, one of the first things that is discussed is the high cost of medical care. Just a couple of weeks ago I had the privilege of serving on a panel for the NRTA and AARP Association. We met in four locations over the state -- at each meeting the number one priority was the same -- the high cost of medical care (which has increased 275% over the past 10 years).

During the last session of the General Assembly, you were instrumental in getting the Medicaid Cap raised to the Federal maximum. However, as you are well aware, it makes no difference what we set as the Cap -- we will always have people whose income is just over the Cap which leaves a large amount to be paid by the patient. Nursing home costs now exceed $1200.00 per month, hospital costs exceed $200.00 per day and Medicare on a national average only pays 37% of the cost of care.

Last year the cost of Health care in the U.S. was 165 billion, yes, 165 billion. Of this cost Medicare and Medicaid paid 42 billion Health care costs now consume 10% of the Gross National Product. At the present rate, cost increases are averaging $1 million per hour.

When I consider the above and that the cost of health care continues to escalate each year, I believe that one of the solutions

would be to implement the Medically Needy Program through the Department of Social Services. This would not resolve all the problems but it would certainly be a step in the right direction.

We all want the quality of health care to improve -- one way to do this is a mandatory training program for nursing assistants, such as aides and orderlies. I feel that most health facilities would welcome the opportunity to hire staff that has a basic knowledge for being a nursing assistant. These are the people who are the front line staff who spend most of their time with patients and help with most of their daily needs. A more competent and better trained staff should certainly help improve the quality of care in all health facilities.

In the past I have talked with TEC, and it is my understanding that they have the capability to implement this training program.

Another plus to this program would be the certification of the people trained. If a person were discharged for cause, a state registry would be kept so this person would not be hired over and over. I feel that this is another way to improve the quality of care in our health facilities.

Several states have passed legislation making this type of training mandatory. I would like to work with this committee to study this matter in more detail.

I recently was investigating a case that revealed something that I feel needs to be corrected. Many times when a patient dies in a nursing home, there is not a doctor present. Consequently the body is removed by the mortuary without being examined by a physician. Still the doctor is required to sign the death certificate and state the cause of death, often without even examining

the body. I have two areas of concern -- one is that I don't think the responsibility of pronouncing the patient dead should be given to the nurse. Secondly, if the physician is not present, how can he accurately state the cause of death? I would hope that this situation could be corrected through legislation or a reinterpretation of existing acts.

Mr. Conrad has been mandated not to discontinue Medicaid services unless he has approval of the Medical Oversite Committee. I feel that this mandate should be extended to other agencies, especially to the Department of Health and Environmental Control. DHEC operates or funds cancer clinics, crippled children's clinic, renal dislysis units and others. Each of these services is life saving; yet when agencies are told to trim their budgets by 5%, no directions are given. Therefore services are cut. Many physicians give their time free of charge or charge a fee less than the ususl and customary charges. This fiscal year appears to be an austere one which makes it even more important to mandate that these services continue. I have been closely associated with these programs this year so I urge you to give special consideration to this request.

I believe that these are some of the more important issues that I recommend that you support during the next session of the General Assembly.

Thank you very much for allowing me to express concerns here today.

Submitted by:
William V. Bradley
State Ombudsman

WVB:ar

Father William F. Pentis
St. Katherine's Parish
P. O. Box 814
Lancaster, S. C. 29720

Senator Rubin welcomed Reverend Pentis, who was a former member "a very valuable one" of the Study Committee and told him how delighted he was to have him appear before the Committee.

Father Pentis addressed the need of families who are taking care of their own elderly at home. After reading his statement which is on the following page, Senator Rubin thanked him for the presentation which supports the efforts of the Committee regarding the pilot project which proves how to coordinate all the agencies and private assistance in establishing a statewide expanded home health service program.

Representative Harris commented on this by saying that due to the concerted effort of Representative Felder $50,000 were added for home health services to last year's Appropriation Bill. "We all recognize the value of home health services which prevent the traumatic transfer from home to an institution and the savings in money once such a program is fully implemented. I think we are on the right track."

Senator Rubin added that when he cited the list of accomplishments achieved last year for the elderly, he forgot to mention that the State has undertaken to pay for the health insurance of State retirees, of which Representative Harris reminded him. "This is an appreciable cost and a very important breakthrough."

 September 21, 1979

Dear Members of the Study Committee on Aging:

I wish to bring to your attention the need many families have for assistance in order to be able to care for their elderly family member(s) in the home. Families that care for their own are by far the majority as only about 5% of the aging are in nursing homes. They care for their own at a much less cost to everyone involved including the government. The elderly are more happy being in familiar settings with their families.

To care for a sick elderly mother or father, grndmother or grandfather takes much dedication and love; it also takes a good deal of money, often over and above what is gotten through social security programs. We need to set up a funding program where families who need financial help to continue caring for their own can obtain it upon verification of the need. The rental of medical equipment and other medical supplies can be very expensive. Supportive sevices need to be increased through the various agencies. One estimate for Lancaster County, for example, is that there are about 15 people home-bound because they are taking care of the elderly, and about 100 that possibly could use medical help.

Another facit of the problem those have who take care of a sick elderly family member is the need for breaks along the way. A day off; a chance for a week's vacation are necessary for the continuation of good happy care of the patient. Can we foster programs that will allow workers to spend an afternoon with such a patient without added cost to the family? Can we smooth the way for Nursing Homes to take in a patient for a one to two week stay while the family gets a vacation and/or break, which stay is taken care of by Medicare or the like?

Ms. Bumgardner of your Committee has information on Home Placement Care for the Elderly as it is now being handled in Tallahassee, Florida. I would urge the Study Committee on Aging to look at this information and see if other States might have other examples.

The whole thrust of much of the aging progam is to help people stay in their own homes. The above suggestions fit well into this aim. I thank the Committee for allowing me to testify. I greet each one of you! May God bless you and the work you do in behalf of <u>all</u> the citizens of this State.

William F. Pentis
P.O. Box 814
Lancaster, S.C. 29720

William F. Pentis

Sarah C. Shuptrine, Director
Div. of Health and Human Services
Governor's Office
Edgar A. Brown Building
Columbia, S. C. 29201

Mrs. Sarah Shuptrine was called by Senator Rubin to speak next. He said that Sarah "did wonderful work for this Committee for many years and moved on to be Director of Health and Human Services in the Governor's Office. With her support and that of the former Chairman, the Governor, we think we have more friends in court."

Mrs. Shuptrine read her testimony which is on the following pages.

Senator Rubin expressed his appreciation for the support of the Governor. There were no questions asked by the members of the Committee.

State of South Carolina

RICHARD W. RILEY
GOVERNOR

OFFICE OF THE GOVERNOR
POST OFFICE BOX 11450
COLUMBIA 29211

Testimony Before

The Study Committee on Aging

by

Sarah C. Shuptrine

Director

Division of Health and Human Services

September 21, 1979

Senator Rubin, members of the Committee, it is an honor and personal pleasure for me to appear before you today to present information regarding Governor Riley's special concerns in the area of health and human services.

This time last year I was working along side you as you endeavored to improve the quality of life for South Carolina's older citizens.

I am here today to assure you that Governor Riley and I, although we are no longer in your midst, continue to share your special concern for the elderly.

On August 27, 1979, Governor Riley wrote to all agency heads advising them of his priority areas for the 1980-81 state budget. The letter and its enclosure are attached. Briefly, these areas as they pertain to the elderly are:

- Support for the Community Long Term Care project in Spartanburg, Cherokee, and Union Counties. This project, as envisioned by the Committee, holds great promise for us to deliver on our mutual desire to have a long term care system which meets the individual needs of our elderly citizens in the least restrictive environment.
- Support for improving our medical care program to provide assistance for the medically indigent - - those persons who are ineligible because of income but who find themselves unable to meet the high cost of medical care due to unusual or catastrophic health conditions. Adoption of "medically needy" criteria would provide relief for these citizens. It would also remove the institutional bias in our present program which has a higher income level for institutional care than for non-institutional care.
- Support for community mental health services.
- Support for community supportive services such as home health care and those services delivered through the local councils on aging.
- Support for coordination of human services and encouragement of volunteerism in the delivery of those services.

Governor Riley wants to encourage improved and expanded health education and self-care programs. Health education is the best preventive health measure available to us and is especially important in later years.

Older people need to become more aware of the importance of giving special attention to such important health needs as proper nutrition.

We are studying ways to improve our property relief program to make it more receptive to those who need it the most.

We will be looking at ways to improve housing for our older people.

We are working with many groups, agencies and individuals in their efforts to improve conditions and provide opportunities for our older citizens.

We will be working on the State and Federal levels to bring about coordinated planning by objectives or desired outcome. Special attention will also be given to coordinated service delivery on the local level.

We expect the Study Committee on Aging to continue to be in the forefront of those efforts and want you to know that we want to work with you as you go about your mission.

Governor Riley will be pleased to personally receive your recommendations when you have concluded your deliberations.

Thank you.

August 27, 1979

Dear

During my first few months in office, I have outlined some basic goals and objectives I believe we should be addressing. These goals and objectives deal with general direction and emphasis that ought to be reflected in services we provide. I wanted to take this opportunity to share my thoughts with you regarding not only goals in your area, but for the entire state system.

We are beginning the preparation of next year's budget. I am aware that you are well into the process of completing your requests. However, I strongly urge you to consider these goals and objectives as you prepare your budget for next year. I believe most of these goals can be addressed within your agency's allocation if we are prudent and responsible in the budget planning process.

In the coming year we will be facing severe financial restraints. This period will require discipline on the part of every state agency. All of us share in the responsibility to live within our fiscal means. To provide the type of service I feel the people of South Carolina need, we will have to redirect our existing financial resources since we will not have funds available to finance new activities.

I look forward to discussing these and other issues with you during the budget hearings.

Yours sincerely,

Richard W. Riley

Attachment

I. GENERAL BUDGET POLICY

A. Personnel

During the past few years, we have seen an alarming increase in the number of state personnel that cannot continue. Therefore, as Chairman of the Budget and Control Board, I will study the budget closely to strive for a zero growth rate in the number of new employees. In addition, each agency should review each vacant position to determine its continuing need. Agencies should continue the practice of actively recruiting minority personnel at all job levels. Finally, employee pay raises in the coming year should not exceed the federal guidelines.

B. New Funds or Programs

The state cannot and should not continue the policy of adding state funds for federal monies that have been discontinued. I will scrutinize these and all other funding changes very closely. We must also put an end to the practice of utilizing non-recurring revenue to fund continuing expenditures.

II. EDUCATION

A. Primary

Early childhood development is a major priority in Education. The early years establish the foundation for a child's study habits, his or her intellectual development, and provide a framework within which a child can achieve his or her potential. Early childhood services should be made available to as many children as possible at an early age, and we should gear our programs to make this goal a reality.

Basic assessment skills evaluation is imperative if we are to correctly diagnose and correct deficiencies, and accelerate those who have excelled. We must also develop and improve remedial programs.

There are other ways we can impact on educational developmental without a great expenditure of funds. We should begin to structure programs that encourage parental and community involvement in public education. These programs can have a tremendous positive affect without establishing an added burden on state funds.

Gifted and talented students, as well as the disadvantaged and physically handicapped, are deserving of programs that give them the opportunity to expand and achieve their fullest potential.

B. Secondary and Tec

Career education, community education and adult education are all important priorities. Half of our young people never go beyond high school. The Design for the Eighties will assist in providing direction for quality vocational and technical programs that give each individual the opportunity to lear a marketable skill and find a meaningful job.

C. Higher Education

In the 1980's the growth of higher education enrollments will decline. To prepare for this decline, we must begin to develop a comprehensive and coordinated plan, along the lines of the Commission on Higher Education's master growth plan. The plan for the eighties must also include comprehensive mission statements that spell out the functional purpose of each college and university in the state system.

III. HUMAN SERVICES

A major goal in this field is not only to improve the level of services provided, but to also achieve a greater degree of coordination between agencies charged with delivering these services.

We must also redefine our programs for the elderly to allow them to remain in their homes and communities for as long as possible.

One of our greatest social concerns has been the breakdown of the family unit. We need to redirect our social service programs to encourage family unity while still allowing access to and use of such services.

Finally, we should begin to emphasize the delivery of preventive services that seek to halt the cycle of poverty that persists in many families.

IV. HEALTH

Infant mortality has long been a critical problem in South Carolina. Health care programs in this area should be directed to identifying high risk births and providing pre-natal and post-natal care and assistance for both mother and child.

There is a great need for a comprehensive long-term care program. This effort should emphasize the coordination of community support services that will allow recipients to receive such care in their home. The use of volunteers to help deliver these services could be a valuable, inexpensive asset we as a state should consider.

The quality of health care matters little to those who cannot afford it. We should move toward establishing "medically needy" criteria that will make health services more available to the medically indigent.

In many cases, mental illness happens because of lack of adequate attention in the early stages. Therefore, we should concentrate our resources on providing community services aimed at the prevention of mental illness.

A major priority must be a continuing emphasis on preventive health care measures. We can have a much greater impact in the health field by stopping illness before it starts.

V. PUBLIC SAFETY

Our emphasis in crime prevention should be on programs that encourage citizen involvement and cooperation, while we direct our investigative and enforcement to deal with non-traditional crimes, such as arson, public corruption, etc.

Judicial reform must be fully implemented, with special attention to the lower court system. Other initiatives should be aimed at making the system more fair, more efficient and more accessible to the public.

In addition, we should examine programs that deal sternly with habitual offenders, and look at possibility of providing reparations for victims of crime.

Our corrections system must be strict, but fair in its treatment of individuals. We need to redefine our direction to temper our treatment of criminals depending on the severety of their conduct. One additional factor is the need to increase the availability and use of alternative rehabilitation methods to decrease the high levels of recidivism.

Our system of jevenile justice must be tailored to direct a youthful offender away from a life of crime. We should seek every opportunity to segregate a juvenile offender from adult criminals, or find viable, productive alternatives to incarceration.

Our emphasis here must be to cut down on the number of highway accidents. We can do this by increased public education and enforcement of our speed laws, education on the use of car safety devices and a reduction in the number of alcohol and drug related accidents.

The state should continue to develop a comprehensive emergency response plan that provides coordination of capabilities at all levels of government.

VI. ENERGY

The energy shortage is a problem in which we all share. Each agency must become more energy conscious and begin to implement strict conservation measures to reduce energy consumption. At the same time, we should initiate programs which will use alternative energy sources.

In the area of nuclear waste, appropriate action must be taken to improve our State's control and monitoring capability over all radioactive materials that enters this State.

VII. NATURAL RESOURCES

All our natural resources are important to those of us here today, and to future generations. There are many unique and fragile ecological habitats that must be managed and protected. One of our primary goals as we grow must be to maintain the proper balance between expansion and our environment.

ECONOMIC AND RURAL DEVELOPMENT

The fundamental policy must be a recognition that the areas of our State are in varying stages of development and have different and unique needs. The efforts of state agencies must be coordinated to see that all unreasonable barriers are removed, and each area of the state can develop according to its own specialized situation.

IX. TRANSPORTATION

Greater coordination of our transportation systems is needed, so we can better utilize available services to meet human needs.

While we must continue to maintain our roads and highways in good operational condition, we should begin to redirect our focus on public transportation to maximize availability and conserve energy.

X. AID TO SUBDIVISIONS

We have begun to lift the freeze on state money to local subdivisions. This process must continue. I am committed to seeing that local governments do not bear a disproportionate share of the burden caused by financial restraints next year.

Mrs. Betty S. Reiner
Mobile Meals of Myrtle Beach
Myrtle Beach, South Carolina

After reading her prepared statement, Senator Rubin thanked Mrs. Reiner for a very fine report.

Dr. Parrish commended Mrs. Reiner for the fine job she is doing on a volunteer basis without funding. He wanted to know if her services would be extended or would the base for operation be broadened if her organization would go under some funded program.

Mrs. Reiner answered that she missed telling the Committee one of the most important things about her operation. Guests are not accepted on the basis that they must pay--40 percent of the guests they serve are non-paying guests. The meals are paid for by people who give financial aid. Sixty percent of the guests pay for their meals; some pay half of the amount. They would like to expand their operation and Mrs. Reiner emphasized that they can do it without any State or Federal help.

Senator Rubin thanked Mrs. Reiner for her presentation and remarked that this type of volunteer action is desperately needed and Representative Evatt and Dr. Parrish have met with church groups and that the Committee will continue the effort to encourage volunteer civic and church support. Government is vitally important in many areas, but it can never do the full job.

(Additional information on the operation of Mobile Meals of Myrtle Beach is on file in the Committee).

I

Mobile Meals of Myrtle Beach

In October, 1976 a group of Myrtle Beach citizens began delivery of meals to people unable, for any reason, to prepare and/or obtain food without assistance. The criteria for service was to be the NEED and references for service comes from phpicians, pastors, Home Healt Care Nurses, friends, family, former guests. Need could be short term or for an extende period. The meals to be delivered to guests by volunteers who use personal automobiles for transportation.

The average number of meals delivered at present is approximately 20-25 daily. Meals served at noon each day Monday - Friday. Menus are planned by a registered dietitian and prepared in a local nursing home.

There is a nominal fee of nine dollars per week per guest. If guests are unable to meet the cost of food service we are able to adjust the fee. We are supported by pledges of financial aid by civic and service and religious groups. At present time approximately 60% of guests pay for meals; one person pays half of cost; and 40% are guests of the program. We are also serving additional meals and fruits to guests who desire them.

All aspects of our service are carried out by volunteers. We have job descriptions for workers and transportation is on a rotation basis of one week every nine weeks for each participating group. One volunteer coordinator prepares route sheets and work sheets weekly.

IV

All who are involved with this project feel the meals are extremely important to each and every guest. We are also convinced the guest is helped by the daily visits of their "friends" who deliver meals. Their physical and mental improvement from well balanced, nutritious meals has improved their ability to maintain their life in familiar, comfortable surroundings. Over a period of time we all see changes occur in their attitude, interest in remaining healthy and active and alert.

Thank you for the opportunity to explain our program.

Respectfully,

(Mrs. Robert N.) Betty S. Reiner

September 21, 1979

Mr. Lee Gaskins, Chairman
Joint Legislative Committee NRTA-AARP
425 Forest Avenue
Spartanburg, S. C. 29302

Senator Rubin acknowledged the presence of Mr. Greg Merrill, who is with the staff of the national NRTA-AARP in Washington, and he expressed appreciation to him for attending this Hearing.

Mr. Gaskins thanked Senator Rubin and the Committee for their fine spirit of cooperation in the interests for the elderly in South Carolina. "Your spirit has been of a high degree of cooperation and meaningfulness and sincerety to the work and interests of our elderly citizens here in South Carolina, and we want you to know that we deeply appreciate what you have been doing."

Mr. Gaskins read his prepared statement which is on the following pages.

Senator Rubin assured him that we will continue to work together. Some of the objectives listed in Mr. Gaskins testimony are long-term goals and Senator Rubin told him that "we fight for funds every year; but we are on the way!"

NATIONAL RETIRED TEACHERS ASSOCIATION

AMERICAN ASSOCIATION OF RETIRED PERSONS

SOUTH CAROLINA JOINT STATE LEGISLATIVE COMMITTEE

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September 1979

EXPLANATION OF POTENTIAL LEGISLATIVE PRIORITIES

a. Support passage of "South Carolina Natural Death Act."

Though passed by the Senate, the "Natural Death Act" never emerged from the House Judiciary Committee. One amendment was attached that would hinder the application of the bill. As designed, the proposed legislation would permit an individual, through prior arrangement with a physician, to specify that life would not be prolonged by artificial life-support systems in the final stage of a terminal illness.

b. Adoption of the Uniform Probate Code, establishing a process for probating standard wills with savings of time and costs.

The Uniform Probate Code, developed by the American Bar Association, establishes a uniform means for settling (probating) simple estates. Adopting this uniform procedure for settling uncomplicated wills has resulted in: 1) more expeditious handling of estates, and 2) savings to the beneficiaries through diminished need for legal assistance. The South Carolina Bar Association has been studying the Code and is to release the results of extensive committee review, with recommendations for action, in the months ahead.

c. Secure funding for state coverage of basic health insurance premium for state retirees.

During 1979, legislation was passed that would have the state pick up the remainder of the monthly basic health insurance premium for state retirees, starting July 1, 1980. At present, the state pays for a portion of the premium for retirees and pays the full premium for active employees. However, funds must be appropriated during the 1980 session, for this to become a reality.

d. Secure funding for increased homestead exemption.

In a move similar to the one discussed in item c, the General Assembly passed a measure in 1979 that, if funded in 1980 and subsequent years, raises the homestead exemption to $15,000. Money must be appropriated in the next session to fund this "intent".

e. Expand health coverage based on "medically needy" concept.

At the present time, requirements of the public health insurance system require an individual exhaust almost all of his/her personal resources before public funds are available to help cover medical bills. Appropriating funds for the type of expansion envisioned under this measure would assure citizens that they would have assistance available without having to become completely impoverished.

f. Promote tuition-free, space-available enrollment for persons 65+ in state-supported institutions of higher education.

Under this measure, persons 65+ would not have to pay tuition for classes at state-supported colleges, universities and junior colleges when there is space available in the classroom. Other class fees, such as lab costs, would not be covered.

g. Expand homemaker/home health aide services, and other community-based support services, to prevent premature or unnecessary institutionalization.

At present, South Carolina has few homemaker and home health aide projects. If a concerted effort is to be made to keep the elderly in their own homes, delaying premature or unnecessary institutionalization, these services must be available as part of a continuum of community support services. (While the three-county project in Cherokee, Spartanburg, and Union counties is moving into the implementation stage, most areas of the state do not have the range of services being tested there. This measure would augment findings from this study.)

h. Establish criteria or procedures before utilities are cut off, including option to pay off utility bill over time.

Last winter, several cases were reported of electricity being cut off during cold spells. While utility companies are not in business to provide their services free, it is important to establish procedures to follow before cutting off gas/electricity when such action would endanger health or life. One procedure might be to require that the utility company make every reasonable effort to insure that a customer has received a bill, that their financial situation is discussed and, if necessary, an extended payment plan is devised to allow the bill to be paid over time.

i. Collect and disseminate information on Medigap insurance.

Under this measure, the Office of the Insurance Commissioner would study the various problems relating to Medigap insurance, and make these findings available to the public. Unscrupulous insurance salesmen offer insurance to supplement Medicare and private insurance policies; many times the additional policies are unnecessary, costly, and/or worthless. While the decision is ultimately up to the consumer as to how much, and what kind, of insurance to purchase, this information could help make the purchaser a wiser consumer.

j. Promote study of day care centers for the elderly.

Another option in the continuum of community services to help keep older persons in their own homes and apartments, and out of institutions, is day care centers for the elderly. This measure would support the study of the feasibility of such centers, potential for state reimbursement and how they might be affected by existing statutes.

k. Support legislation requiring automobile insurance rates be tied to driving record.

This measure would require that driving ability (as indicated by one's driving record) would be the sole criteria for setting premiums for automobile insurance. The theory is that good drivers, of whatever age/sex/place of residence, should not have to underwrite part of the premium of the bad driver. If one's driving record improved, or stayed clean for a specified period following an accident or other indicator, one would be eligible for lower rates.

l. Place consumer representatives on all regulatory commissions/boards.

A series of bills to place at least one consumer on all boards/commissions regulating certain businesses and professions in South Carolina were introduced in 1979. Having a consumer on bodies licensing and regulating an industry/profession would help insure that the public has a voice in decisions affecting that business.

m. Maintain cost-of-living adjustment for members of state retirement system.

The cost-of-living adjustment for members of the state retirement system was increased from 4% to 6% in 1979; that change applied only to fiscal year 1979/1980. Future sessions must decide if that level of adjustment will be maintained and make the necessary appropriations.

n. Explore alternate uses of community facilities (e.g. schools) for fuller utilization by all citizens.

At the present time, many public buildings are not available to all citizens. Some use might be made of these buildings during non-peak hours, especially as the communities begin to look to offer a wider range of services and activities to all citizens.

o. Support development of a new type of service position, a "home aide", to live-in with an older/disabled person, as another option to decrease institutionalization.

This measure would make funds available to develop a program to train "home aides", as an addition to the community-based services network. As envisioned, these persons would live-in with an older or disabled person who otherwide would not be able to remain in his/her home, doing simple chores and rendering limited health-related aide. Certification would be required after training; reimbursement would be on a sliding scale, depending upon the resources of the homebound person.

p. Increase state attention to, and appropriations for, solutions to the transportation needs of the elderly.

This item would direct state attention to the transportation needs of the elderly, support studies on improving/coordinating existing services and request necessary appropriations.

q. Support establishment of measures promoting preventative health care.

At the present time, the orientation of health care is to cure problems; if more emphasis were placed on preventing disease and maintaining health, costs could be controlled better, and the overall state of health could be improved.

r. Establish a Hospital Rate Review Commission, as one means to control inflation in the health care field.

Such a body would monitor rates charged by hospitals for the range of services they provide. Depending upon the strength of the enabling legislation, the Commission could have authority to recommend or even require that rates in excess of established or conscionable increases be rolled back. The establishment of such a body is one weapon in an arsenal of means to establish more control of the spiraling costs of health care.

Presented by
Lee C. Teachman.

Dr. Allen Edwards
AARP, Catawba Chapter
Rock Hill, S. C.

Dr. Edwards read his statement which listed priorities which the Catawba Chaper of the American Association of Retired Persons would like to have enacted into laws with the Study Committee's assistance.

Senator Rubin told Dr. Edwards that he was proud of the fact that the Senate Medical Affairs Committee helped expedite previous legislation on which the AARP asked support; for example, legislation dealing with eyecare and generic drugs. After good work in the House by comparable committees and through coporate inter-relationships, much can be accomplished.

There were no questions asked of Dr. Edwards.

CATAWBA CHAPTER, AARP, ROCK HILL, S. C.

of the AMERICAN ASSOCIATION OF RETIRED PERSONS, Inc.

Statement by Allen D. Edwards before the STUDY COMMITTEE ON AGING,
September 21, 1979

The Catawba Chapter of the American Association of Retired Persons wishes to express appreciation for the work of the Study Committee on Aging.

Our chapter places a high priority on the following five items:

1. Community based services to enable persons to remain intheir own homes as long as possible. These services would include home health services, homemaker services, transportation, and day care centers.
2. Enactment of a Uniform Probate Code. It is our understanding that the Estates Committee has concluded their study and has a report which may be ready for consideration of the legislature in January.
3. Expand health coverage for the "medically needy". This is needed to take care of catastrophic illnesses for persons who are not eligible for medicaid.
4. Increase efforts to train workers involved in services to the aging in hospitals, nursing homes, and private residences. A home aide to live in with an older or disabled person could prevent institutionalization in many cases.
5. Cost containment for health services and funerals.

In addition to these top priority items, we support the following:

6. Passage of the "Natural Death Act".
7. Funding to continue the cost of living adjustment for State retirees.
8. Funding for the Homestead Exemption at the $15,000 level.
9. Reform of regulatory commissions including the placing of consumer representatives on all commissions.
10. Exploring alternate uses of community facilities (e.g. schools) for fuller utilization by all citizens.

Virgil L. Conrad, Commissioner
Department of Social Services
P. O. Box 1520
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Mr. Conrad expounded on the program expansions which the Board of the Department of Social Services has incorporated into its FY 81 planning year which would directly impact the aging citizens of South Carolina .

Over the last two to three years, the Board and staff of DSS have been trying to establish credibility and capacity to manage the Medicaid Program. It has grown in terms of cost and service. In 1974, about 40,000 aged, blind and disabled people, now, with Federal legislation and Supplementary Security Income, about 85,000 citizens receive this Program, which means they receive their medical benefits from State and Federal funds, known as the Medicaid Program. Due to this increased number of citizens being served, there has been an increase in demand for State and Federal dollars to provide these services. Mr. Conrad was pleased to report to the Committee that the outstanding audits which went back to 1971 have been completed; they have been able to collect back for the State and Federal governments some 5 million dollars of delinquent accounts.

Mr. Conrad highlighted the following areas and then ended his presentation with a brief status report on the Medically Needy Program.

Community Long Term Care Project—This concept was put into operation in Union, Spartanburg and Cherokee counties where programs and policies and their cost and utility to the citizens of this State to enable them to remain at home could be tested before statewide policy is made. Mr. Conrad understands that the waiver at the national level has been approved, but written confirmation has not yet been received. Additional funds will be requested in this project area to test the concept of home health care; a program which is aimed to make it possible for individuals to remain in their homes by paying a nominal fee to a friend or relative to act as a caretaker—personal services. This concept has been demonstrated in other states to be a valuable resource, one of the most notable is the State of Oklahoma. Additional funds will be needed in the amount of approximately $154,000.

Medical Day Care—A pilot project was established in the Appalachian county of Greenville. About $82,000 will be needed to expand this into the other Appalachian counties of Pickens, Anderson and Oconee.

He urged the Committee to make an expression to the Joint Appropriation Review Committee, which will be reviewing on October 5, on the expansion of the Personal Care Project to Richland, York and Lexington Counties. The Personal Care Project has been operating in Newberry, Fairfield, Lexington and Chester Counties. Funding was received through CETA public service employment slots to employ AFDC (aid to families with dependent children) mothers to train them with WIN funds—minimum cost to the State of South Carolina—and thus have been able to provide services to the senior citizens in their homes. Of the 44 people in this project—that is 44 people who do not receive that AFDC check—17 have already moved into unsubsidized employment: they have moved on as professionally trained caregivers to work in a nursing home or some other medical institution. Here is an opportunity to take a tax consumer, provide training through Federal funds and open employment opportunities. Assurance was given to DSS from the Manpower Director in the Governor's Office that they could receive an additional 38 slots to expand it into the counties mentioned. In these counties where this program has been implemented, a cost analysis of other services by different caregivers was made. As many as five social services programs—financed out of Title XX program—were going to a person's home. However, by sending one personal caregiver, they were able to provide more hours of service at a reduced cost. They would like to expand and study this program and as it mirrors much of the health care concept mentioned by Mr. Conrad earlier, at a future date, they would like to merge these and get the matching to the State dollars out of the Medicaid Program. "What we are able to do in these counties was provide services to clients who were on waiting lists to be admitted to a nursing home and do it much more effectively," said Mr. Conrad.

Homemaker Program—This is another Program that they would like to expand. It will also achieve the objective of permitting individual citizens to remain in their homes. An additional 141 homemaker positions will be asked for in the upcoming budget year; this will enable DSS to provide services not only to the elderly but also to the families. It will teach them homemaking skills and allow them to have independent living situations.

Legal Services--By changing some of the priorities internally of the Department, they will be able to give additional legal resources to protect adult citizens from any type of physical or other abuse. This will not require an expanded budget request in FY'81.

General Assistance Payments--An increase will be requested from $60 to $78. This Program goes to some of the elderly citizens; it goes to those ineligible spouses who are not eligible for a SSI income.

Another modest increase will be asked for to compensate for the minimum wage impact on residential care homes, also referred to as boarding homes.

In closing, Mr. Conrad talked about the nursing home and the Medically Needy Program and the Medicaid "cap." He said that he has tried to realistically project the need for institutional beds balanced with the program coordination and innovation which will enable citizens to remain at home. In the FY '81 budget are 400 new beds to be constructed. The "cap" is now at $624.60; the General Assembly will be asked to add a proviso to assure, in lieu of the Medically Needy Program being established, that we will always keep that "cap" at the maximum amount. This can be done by saying that the "cap" would be 300 percent of the SSI (Supplementary Security Income). The SSI is currently $208.20, so the current $624.60 represents 300 percent of that. Mr. Conrad said it would be helpful to have that proviso in the DSS section of the budget or the permanent section that would authorize the "cap" to stay at 300 percent of the SSI level. This way there would always be the automatic update. The SSI is subject to increase each July 1, and it usually goes up 9 to 10 percent; this would give an incremental adjustment to help our citizens in lieu of the Medically Needy Program until its completion.

Medically Needy Program--The concept of this Program is to serve additional citizens. DSS has been charged with the responsibility of not only in the Department's individual section by a proviso to complete a comprehensive study, but also by a Senate-passed bill. DSS is very hard at work in doing this process right now. Mr. Conrad has identified to the DSS Board preliminarily that the first review would indicate that about 3.1 million dollars of State funds are needed to launch this Program. He emphasized again that this is a preliminary study; the Board has authorized Mr. Conrad to include that in his presentation to the Budget and Control Board. Mr. Conrad assured the Committee that he will continue to study this. First to establish is the Program cost in terms of the

population that might be eligible, then identify potential revenues, such as local or State dollars that are already going into this area, and then those that might be needed and lastly they will look at the administration of the Program. Mr. Conrad plans to make a detailed report to the General Assembly in early January so that the members will have the full term to analyze and evaluate the merits of that Program and hopefully fund it.

Mr. Harris wondered if we need to further look at a spend-down approach since we have the 300 percent of SSI. Mr. Conrad told him yes and that he will have recommendations on that. He pointed out that there is a tremendous gap between the $624.60 particularly when you move into institutional payment, be it a nursing home or hospital. The cost is very high when you need that kind of medical care and you can soon consume all of your resources that you have been able to accrue over a lifetime. "We do need to move in that direction, and I will be bringing recommendations to the General Assembly," Mr. Conrad said.

Senator Rubin thanked Mr. Conrad for his information and recommendations and told him that he has raised so many vital points that the Committee has to be in close touch with him in the future. "We appreciate the great job you are doing with DSS; you have earned the confidence of the members of the General Assembly."

PRESENTATION
TO THE STUDY COMMITTEE ON AGING
September 21, 1979 - Senate Chamber

By: Virgil L. Conrad, Commissioner, S.C. Department of Social Services

The Department of Social Services has incorporated into our FY'81 budget proposal requests for funds for several program initiatives which would directly impact the aging. Each will be discussed briefly below.

MEDICALLY NEEDY - We are charged by the Appropriations Act to conduct a study of the medically needy program. We are currently involved with this study and will complete it this year. At present we have no further report to file beyond the one which we filed with your Committee last year.

COMMUNITY LONG TERM CARE PROJECT - As you are aware, we are working with the Commission on Aging, the Department of Mental Health and the Department of Health and Environmental Control in conducting a community long term care project in Union, Spartanburg and Cherokee counties. We are requesting funds to establish two new programs to help maintain citizens in a noninstitutional seeting.

HOME HEALTH CARE - We have requested funds for this project to be implemented on a pilot basis in the three counties under the Community Long Term Care Project. Those counties are Spartanburg, Union and Cherokee. The aim of this program is to make it possible for individuals to remain in their own homes by paying a nominal fee to a friend or relative to act as a caretaker. We feel this is an alternative which must be explored, expecially in the face of rising nursing care costs and the limited number of nursing beds available. If this pilot proves to be successful we would like to expand the service to the rest of the state.

MEDICAL DAY CARE - This service will also be provided, initially, on a limited basis. We will deliver this service in already existing licensed nursing homes. There are two advantages to this program. The first is the ability of the client to remain in his own home longer than might otherwise be possible. Secondly, clients who are discharged from the hospital may, by attending this type of day care, reach a rehabilitative level that would not be possible without this service. Every one of our current nursing facilities has the space to provide this type of service, and we look forward to expansion during FY'82.

HOMEMAKERS - We are currently staffed at only 60% of need for homemakers. These workers provide services essential to maintain many elderly citizens in their homes. They also work with families to improve neglective and abusive environments, thus providing protective services. We are requesting 141 new homemakers so that these services can be expanded.

NURSING HOMES - We are planning to fund additional nursing home beds on a decreasing incremental basis. FY'80 - 500 new beds; FY'81 - 400 new beds; FY'82 - 300 new beds, and FY'83 - 200 new beds; FY'84 - 100 new beds; FY'85 - - 0 new beds.

INCREASED MONEY PAYMENTS - We are requesting that our General Assistance payment levels be increased to $78 per month. This program includes ineligible spouse payments which frequently go to spouses of elderly people. We are also requesting that the rate to be paid to residential care facilities be increased to provide funds for the increase in the minimum wage level.

LEGAL SERVICES - This year we are giving special emphasis to legal services for adult protective services. This should help us protect our elderly from abusive and neglective situations.

James B. Drennan, III, Chairman
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Referrrring to the Uniform Probate Code, Mr. Drennan said that what they have come up with is not the UPC per se; it is something that they call the proposed South Carolina Probate Code. The UPC was utilized as a basis or tool on which to review the S. C. law. In many instances, the provisions of the UPC were adopted, in some other instances they felt that the existing S. C. law was preferable. He admitted that in some instances neither the UPC nor the existing S. C. law was best and in these cases they came up with a better idea.

Mr. Drennan's statement is on the following pages.

Senator Rubin wanted to know when the final proposals will be ready and Mr. Drennan said that the House of Delegates will meet in November and he hopes that they will approve amendments which have been made by the Estate Practices Committee and that the legislative process can begin thereafter.

STATEMENT REGARDING PROPOSED SOUTH CAROLINA PROBATE CODE

By

James B. Drennan, III, Chairman,
Estate Practices Committee of the South Carolina Bar

The Estate Practices Committee of the South Carolina Bar has for several years been engaged in a detailed review of the Probate and Probate-related laws of South Carolina.

Assisted by several Probate Judges appointed by the President of the State Probate Judge's Association, the Committee has used the Uniform Probate Code as a reference point in its examination of South Carolina laws.

In March, 1978, the Board of Governors of the South Carolina Bar approved the proposed South Carolina Probate Code, which embodies what this Committee believes to be an advantageous combination of Uniform Probate Code provisions, extant provisions of South Carolina law, and some provisions which are believed to be an improvement upon both.

The proposed Code was submitted to the House of Delegates of the South Carolina Bar in June, 1979, and was approved, with the exception of the provisions on Probate Court jurisdiction and the elective share of a surviving spouse, which the Committee was directed to review again and report back to the House of Delegates in November, 1979.

The Committee has since met several times and it is hoped that the amended provisions on jurisdiction and elective share will be approved by the House of Delegates in November, so that the legislative process may begin.

This Committee feels that the adoption of the proposed South Carolina Probate Code will benefit the citizens of this State in many particulars, including the following:

1. Simplication of the Probate process, particularly where all interested parties are willing to administer an estate informally.

2. Revision of the laws of intestacy to provide a larger share of an intestate estate to a surviving spouse, particularly in smaller estates and in estates in which all children of the deceased are also children of the surviving spouse.

3. Abolition of dower and the substitution of an elective share to a surviving spouse.

4. Clarification and specificity in the laws regarding the estates of minors and incompetents and their persons.

5. Clarification of the jurisdiction of Probate Courts, including an express grant of authority over trusts.

6. Revision of the South Carolina Durable Power of Attorney Act to resolve certain problems and questions which have arisen with respect thereto.

In summary, this Committee feels that the adoption of the proposed South Carolina Probate Code will be of substantial benefit to the citizens of this state, particularly those who are most directly affected thereby: the elderly.

Respectfully Submitted,

James B. Drennan, III, Chairman
Estate Practices Committee
South Carolina Bar.

Edward W. Rushton, Exec. Director
Orangeburg County Council on Aging
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Mr. Rushton spoke on multipurpose Senior Centers, nutrition services and transportation problems. His statement is on the following pages.

Senator Rubin appreciated Mr. Rushton's informative presentation. There were no questions asked.

Senator Rubin and Members of the State Study Committee on Aging:

It is my privilege to represent the Orangeburg County Council on Aging. Mr. Chairman, I'm sure testimony on various needs will be ably presented at this hearing; therefore I shall confine my remarks to three obvious and consistent needs of the elderly, namely, multipurpose senior citizen center, nutrition program, and transportation.

The Multipurpose Senior Center - The Characteristics

A multipurpose senior center is a community facility in which older persons may come together to fulfill many of their social, physical, emotional and cultural needs. As part of a comprehensive strategy, senior center programs take place within and emanate from a facility; however, satellite community services and activities may contribute to the enhancement of the comprehensive center facility operations. A center can help expand their interests, motivate their aspirations and develop their talents. It is a home base of friendship and belonging. In fact, it is a teaching-learning center.

A center is also a linkage to bring together a loose-knit senior community into a larger community setting. It is a home away from home.

Many older persons feel isolation, rejection and deprivation. A center bridges the gap and enables them to participate in a wide range of vocational, recreational and cultural activities in a conducive, non-competitive atmosphere.

A senior center is not for older citizens only. Volunteers of all ages interact and interrelate with center members in varied programs. For example, it has been shown that the generations' gap can be bridged when youth and older citizens get together for "rap sessions" and view problems and issues from a perspective of time. The older generation can be objective and exude compassion with young persons and their concerns. The young, the middle-

aged and the old teach and learn from each other.

A senior facility is one indication of the community's concern for its citizens, just as schools are evidence of the community interest in children and youth. An attractive and functional center has positive meaning to older folk while warehouse, church-basement and outmoded settings can serve to reinforce feelings of rejection and a "devil may care" attitude. Adequate space, location, attractive facility and surrounding, including health, safety and esthetic features can actually change out-dated community attitudes toward the elderly.

Another attribute is that the center stimulates opportunity and options regarding a loss in status of retired persons. Leadership roles, with group approval, contribute immeasurably to self-confidence, self-respect and a new lease on life.

The Program

The program is the justification for a senior center. Generally speaking, the program includes all the activities and services that take place at the center or in the name of the center. The program should be integrated and fused into the community. This concept enables older persons to participate in planning and implementing program elements.

With the center being the focal point of operations, other community agencies and groups can aid and make possible satellite locations and resources for the full development of program elements. Cooperative relations and utilization of community facilities and resources become a vital linkage for services and activities on an on-going basis. This involvement enables a center to become truly a multipurpose operation.

Obviously, no single center can offer all the program elements needed for senior citizens. The center serves as a rotary wheel around which the program revolves and a hub from which center impetus for activities and services emerge.

The program should be geared to a wide scope of activities and services with respect to individual and group needs. Among the significant ones are the following: information, referral and outreach; employment opportunities; health services; education programs; homebound offerings; transportation services; recreation activities; nutrition benefits; social events; community participation; and, other auxiliary services.

The Multipurpose Senior Center - The Need

This local situation is in a predominately rural county in South Carolina. Several make-shift senior centers have been in operation here for four years.

This center is a private, non-profit agency, charted in South Carolina and has tax exempt status. The Board of Directors consists of county-wide concerned citizens regardless of age. The agency provides programs under the rules and regulations of Title IIIB, IIIC, V and XX. Funding is received from the South Carolina Commission on Aging, The Lower Savannah Council of Governments, the Orangeburg County governing body, the Orangeburg City Council, the United Way, and local donations and contributions.

The population of the county is 78,600, of which 10,900 citizens 60 years of age or older reside in the county and within commuting distance to the center. Transportation from a federally funded agency is provided in addition to privately owned vehicles.

This center is an adjunct to an abandoned school building constructed in 1916 and is located in a rapidly deteriorating area. The facility is obsolete, inadequately designed and space restricted for functional program elements. It is accessible from one narrow entrance. The site contains limited land unsuited for outdoor activity. An intensive search has been made for a more desirable facility but to no avail.

Acquiring expansion of the existing facility, altering or renovating the

center would not only be impracticable but uneconomical. Any expenditure, except for minimum maintenance, would defeat the purpose of providing a defensible program for older Americans.

The logical solution is obviously a new and adequate facility, located on an esthetically pleasing site, sufficient outdoor space for year-round use. The local climate is conducive to many outside activities throughout the year.

Experience has shown that it is more economical in construction cost, including program delivery services, to build new facilities rather than add, renovate or alter old buildings that are already obsolete, poorly designed and structurally incapable of providing space for acceptable programs and services.

Architects and educational planners have shown conclusively that the abandonment of obsolete school plants and their replacement with new buildings saves money and, more importantly, provides better teaching-learning spaces for the improvement of instruction.

We have learned that modern and updated plant facilities contribute to better morale, higher levels of aspiration and increased productivity.

Senior Center Proposal

The Federal Register, Volume 44, No. 148, Tuesday, July 31, 1979, Subpart H, Section 1321.121, states that the area agency may award social service funds under this part for senior activities such as construction. Construction means the building of a new facility, including the costs of land acquisition and architectural and engineering fees. I have requested, upon approval of the Orangeburg County Council on Aging Board of Directors, funds for a new senior citizens facility to the area agency.

In the event that federal funding should be made available for a facility, there will be a match required from state or local sources. Mr. Chairman, I suggest for consideration by your committee that the local community provide land acquisition and that the state make available the match for capital outlay for the physical facility.

Nutrition Services

In view of a somewhat detailed description of an urgent need for a defensible senior facility, permit me to call attention to nutrition services to provide meals and home delivery nutrition services, including education, to older persons. In Orangeburg County, our agency provides congregate nutrition services; two small satellite centers for meals, including educational and recreational activities; and a limited number of home-delivered meals for shut-ins. At our congregate site 250 meals are prepared and served to participants on a daily schedule, Monday through Friday. We have a waiting list of older citizens who need nutrition services amounting to 260.

Even though our kitchen facilities are taxed to the limit, extension of a food preparation area could be made at minimum expense. Cost-quality nutrition services at our congregate site compare most favorably with catered service for meals in the state.

I request your consideration of an expansion of federal funding to assist in this basic necessity of healthful living for the elderly. As part of a matching requirement for nutrition services, participant cash contributions are available to support these services maximally. It should be stated also that maintenance of kitchen equipment and utility costs are borne by the county governing body.

Transportation

Our third request for consideration is undergirded by more adequate transportation services. Orangebury County is predominantly a rural area. Public transportation service in the city of Orangeburg is not available, except through taxi and private automobile. Outside the city, transportation is non-existent.

In the Federal Register, Volume 44, No. 148, July 31, 1979, cited above in this presentation, section 1321.193, states that the state agency must spend in each fiscal year for services to older persons in rural areas under this part at least 105 percent of the amount spent under the Act in rural areas during Fiscal Year 1978 for social and nutrition services and multipurpose senior centers. Obviously, it is the intent of the federal government that older persons living in rural areas be given special attention.

Our agency depends upon limited transportation services from the Orangeburg Area Committee For Economic Progress. Transportation is a critically needed service. At times throughout the year transportation is curtailed due to lack of funds. It is frustrating and really disappointing for older persons making the effort to get ready to come to the center, wait on a bus and no transportation vehicle arrives. This problem is one of the most exasperating concerns we encounter. Our programs, services and activities are geared to their desires and needs. It seems unreasonable to try to be of assistance to the elderly and they have no way to get to the center; moreover, many of these people have shopping to do and to attend to other vital matters. In rural areas the elderly desperately deserve transportation. My appeal to you is to use your strong influence to help remedy this situation.

As a final note, it has been my good fortune to be associated with senior citizens in an active capacity since 1974. These older citizens are appreciative, cooperative and eager to participate in activities for the welfare of all age groups. Why not? They have endured the hardships of two world wars, the great depression and the Korean and Vietnam conflicts. Throughout those national and international holocausts and other difficult

years, they have made contributions in keeping America "the arsenal of democracy" and the greatest nation on earth. Whatever we can do to help these deserving and worthy citizens today and over the years ahead will redown to our benefit and to the generations yet unborn. I thank you for allowing me to speak in their behalf.

Edward W. Rushton, Executive Director
Orangeburg County Council on Aging

September 21, 1979

Morris E. Fonda
Aiken Area Council on Aging
P. O. Box 235
Aiken, S. C. 29801

Mr. Fonda, a member of the Board of Directors of the Aiken Area Council on Aging, spoke on the need for a regulation on supplementary health insurance for people on Medicare, which, in his opinion, is one of the major problems facing senior citizens today.

He urged support of a proposed regulation aimed at eliminating unfair and deceptive practices in promotion, solicitation and sale of individual accident and health insurance. This proposed regulation--drawn up by the S. C. Department of Insurance and the Commission on Aging--will be filed with the Legislature next session.

Mr. Fonda's presentation is on the following pages.

There were no questions asked of Mr. Fonda.

A Statement by Morris E. Fonda, a Retiree and a Member of the Aiken Area Council on Aging Board of Directors, on the Need for a Regulation Concerning Individual Health and Accident Insurance Policies Relating to Deceptive and Unfair Practices in the Promotion and Sales of Such Policies, and the Need for an Appraisal of Organizations Selling Medicare Supplementary Insurance to Those Persons who either do Qualify or will Qualify for Medicare Insurance.

One of the real enigmas for persons who are planning for retirement and who will at that time qualify for Medicare, is how much supplementary insurance should they secure, what companies supply it and at what cost, what do their respective policies cover and can they accept as truth and fact the information a representative of a company offers them. It is simply not enough to instruct a potential or present Senior Citizen to read the fine print. Most of us are not sure as to what the fine print really says or means.

In my own case, I devoted many hours investigating and studying this problem. It is unfortunate, but I believe a fact, that most people don't understand what Medicare itself covers. We may discover that it civers 80% of hospital and medical costs, after certain deductions. But that doesn't necessarily cover 80% of all the costs. If the hospital or

physician charges exceed what Medicare has determined should be a fair charge, then that 80% just covers what they allow and not the exceeding amount. That's lesson number one.

After I discovered that fact, I checked into supplemental insurance that would pay the 20% Medicare coesn't include. But again that 20% is the amount Medicare allows and not necessarily 20% of the total bill. That was fact number two. So then I started my investigation of still another insurance to supplement the Medicare and the first Supplemental Insurance Policy. I'm sure it's logical to assume that these two would cover most costs....and I'm sure they would. But my wife and I had worked hard during our lifetime to save for retirement so we would be self sufficient. I did not want to take any chances on large hospital or medical costs depleting our financial resources. So we took another policy.

Sure enough, in my third year of retirement I had a serious physical problem that required both major hospital and medical costs. Without that last policy I would have had to pay a significant amount beyond what Medicare and Blue Cross allowed. But now I'm questioning whether I can afford all of this insurance at a cost, beyond Medicare, of over $900.00 annually. In the meantime I have had salesmen call on me regarding other supplementary Medicare insurance. In addition, my Sunday paper often has a promotional piece on a particular type of supplemental insurance...covering a particular type of condition.

I believe it is fair to say that the whole matter of Medicare supplemental insurance is one of the major problems facing Senior Citizens today. Older Americans are very vulnerable to presentations and promotion material information that is not clear and concise on what a specific policy covers...and what it does not cover. The "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE", developed jointly by the National Association of Insurance Commissioners and H.E.W. is helpful. But I don't believe any national publication can be specific enough to be meaningful in a particular state.

Some states have already recognized this problem. The office of the Commissioner of Insurance in Wisconsin has published a booklet in which they evaluate 13 companies supplying supplemental insurance in that state. This evaluation is on a scale from one to four and I am including a copy of just the evaluation (not the entire booklet) for your information.

The August 20, 1979 edition of the Wall Street Journal reports on what New York State has very recently completed in their studies of companies furnishing Medicare supplemental insurance in that state. It is interesting to note that the article states that on a scale of 1 to a 100, 32 of the 47 plans rated scored less than 50 with 13 scoring under 10. Again, I think this emphasizes how vulnerable a senior citizen can be to any type of deceptive selling methods.

I am happy to report that both the South Carolina Department of Insurance and the South Carolina Commission on Aging have recognized this problem and are working together to do something about it. This awareness of the problem has been recognized in correspondence which I have received from both of these agencies. They have developed a proposed regulation aimed at eliminating unfair and deceptive practices in promotion, solicitation and sale of individual accident and health insurance. It is my understanding that this regulation will be pre-filed with the legislature when they convene in 1980. I urge your support of this regulation.

However, I believe both of these agencies should continue their good work to include what supplemental insurance can best fill the gaps that Medicare leaves uncovered. This should include an evaluation of each company selling Medicare supplemental insurance in South Carolina using such factors as price-benefits, a study of random but typical cases and what a respective policy would cover, its overall coverage such as for drugs, nursing home costs as well as hospital and physician charges, and related factors. This would neither be a recommendation for nor discrimination against any one company but would offer the person considering insurance their options and selections for what they wished.

As far as distribution of this information, I believe the various Councils on Aging would be one means of seeing

that such information was properly distributed. I'm sure most of them have newsletters and other ways of getting this information to the interested parties. Also the insurance industry could develop a program to see to it that their people were informed in a manner that would emphasize a non-sales atmosphere.

I strongly recommend that your committee encourage both the South Carolina Insurance Commission and the Commission on Aging to continue their good work in the further development of this program. The proposed regulation is very good and I hope the legislature approves it. But equally important is the evaluation of companies furnishing supplementary health insurance in South Carolina, emphasizing what their respective policies do and do not cover and the costs involved.

Thank you.

MEF:mab
9/19/79

OFFICE OF THE COMMISSIONER OF INSURANCE
123 West Washington Avenue
Madison, Wisconsin 53702

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Medicare Supplement Policies
Approved under Ins 3.39
as of
June 1, 1979

Name of Company	Policy No.	Category	Annual Premium by Ages			
			65-69	70-74	75-79	80+
merican Motorists Long Grove, IL 60049	IM5847WI	2	$473.00	$575.00	$687.00	$809.00
Bankers Life 711 High Street Des Moines, Iowa 50307	GW908	1	$216[1]			
Blue Cross of Wisconsin/ Surgical Care-Blue Shield 401 W. Michigan Street Milwaukee, WI 53201	X95 7	2	$210.00[1]			
			65	73	80	
Central National Life 110 North East Street Jacksonville, IL 62650	GA 6960	3	$264.00[2]	$341.00[2]	$414.00[2]	
			65-69	70-74	75-79	80+
Lumbermens Mutual Casualty Long Grove, IL 60049	IA5847WI	2	$473.00	$575.00	$687.00	$809.00
MidAmerica Mutual Life 2021 E. Hennepin Ave. Minneapolis, MN 55413	U-1085	3	$277.50			
Mutual of Omaha Dodge at 33rd Street Omaha, NE 68131	50VB	3	$230.28[1]			
			65-69	70-74	75+	
National Home Life 211 E. Capitol Ave. Jefferson City, MO 65101	4200WI	3	$257.54	$313.61	$375.19	
			65-70	71-75	76-80	81+
Personal Indemnity Mut. Ins. Co. 6150 W. Fond du Lac Ave. Milwaukee, WI 53218	8678	3	$346.00	$406.00	$442.00	$465.00
Physicians Mutual 115 S. 42nd Street Omaha, NE 68131	P-182	4A	$205.09[1]			

(Over)

			65-72	73-79	80+
Reliable Life & Casualty	GR646	2	$446.00	$502.00	$646.00
3321 W. Beltline Hwy.	GR645	3	$396.00	$442.00	$586.00
Madison, WI 53711					
Rural Security	HP-191	2	$185.83[1]		
7010 Mineral Point Road					
Madison, WI 53705					
WPS	11193-051	2	$211.20[1]		
P. O. Box 1109	780 1				
Madison, WI 53701					

[1] Premium is the same for all ages.

[2] Premium is step-rated with a varying increase with each age.

Ms. Carolyn C. Bain, Supervisor
Social Services
Aiken Area Council on Aging
P. O. Box 235
Columbia, S. C. 29801

Ms. Bain spoke on the effect of escalating gasoline prices on volunteers who deliver meals to homebound elderly people. Most of these volunteers—approximately 60 percent—are over sixty and on limited income and rising gasoline prices are becoming a significant problem for them.

The National Association of Meals Programs has written to James Schlesinger, Energy Director, and requested that home delivered meals be considered an essential service and that volunteers should be allowed to document their mileage and receive reimbursement either through extra rationing coupons or some other government-established mechanism. Since most of these volunteers are over 55 and on a limited and/or fixed income, all that is needed is a short form income tax return, and a deduction would not benefit them.

Ms. Bain urged the Committee to find a solution to this problem.

Her statement is on the following pages.

Senator Rubin thanked Ms. Bain for her testimony and said that this problem is one we have to be very concerned with. He expressed his appreciation to Ms. Bain and Mr. Fonda for bringing these crucial matters to the attention of the Committee.

Statement by Carolyn C. Bain, Supervisor of Social Services for the Aiken Area Council On Aging, Aiken, South Carolina on the Need to Deal With the Effect of the Escalating Cost of Gasoline on the Volunteers Who Deliver Meals to the Homebound Elderly.

As an agency that operates a Home Delivered Meals program for the homebound elderly citizens of Aiken County, we are becoming increasingly concerned at the escalating costs of automobile fuel. Since our program utilizes the services of approximately 250 volunteers who deliver these meals without reimbursement for gasoline expenses, and without whom we could not function, our future ability to continue this program at present levels is in jeopardy.

During the first six months of this year a bank of more than 250 volunteers contributed 4,234 hours of time to the agency and drove 17,462 miles. The major portion of these hours and miles were accrued in delivering meals. The agency gains substantially in monetary terms because of these contributions. The dollar value given to donated miles and hours for the first six months of this year was $14,780.05. And the job could not be done without the volunteers. The Council On Aging does not have the staff nor the money for mileage that it takes to deliver 85 meals throughout most of Aiken County each day of the week.

We have not yet lost too many volunteers due strictly to the cost of gasoline, but we feel certain that this factor is at the root of the excuses we have been given for the volunteers who have quit. Our volunteer coordinator is finding it more and more difficult to find substitutes on days where our regular volunteers are unable to work; and fewer new volunteers are calling to offer their services. We are sure this decrease in calls is due to the increasing price of gasoline. Approximately sixty percent of our volunteer force are over sixty and are on limited incomes. The rising cost of gasoline is especially significant for them.

The National Association of Meals Programs has requested of Mr. James Schlesinger,

Energy Director, that Home Delivered Meals be considered an essential service and that this could be accomplished by allowing volunteers to document their mileage and receive reimbursement via extra rationing coupons or through some other government-established mechanism, other than a tax deduction. Since many of the volunteer deliverers are over 55 and on limited and often fixed incomes, all that is needed is a short-form income tax return, and therefore a deduction would not benefit them.

In the hope that this problem will be addressed and an equitable solution found, we strongly endorse the above request and urge that you support it also.

Dr. Ernest A. Finney, Chairman
S. C. Commission on Aging
915 Main Street
Columbia, S. C. 29201

Dr. Finney spoke on amendments to the Older Americans Act which require an increase in the non-federal matching funds from 10 percent to 15 percent for nutrition and social services provided under this Act for the FY 1980-81. This additional 5 percent must come from State sources in cash and will require an additional State appropriation to the Commission on Aging in the amount of $330,175.

There were no questions asked of Dr. Finney.

REMARKS BY DR. ERNEST A. FINNEY, CHAIRMAN
SOUTH CAROLINA COMMISSION ON AGING

TO

LEGISLATIVE STUDY COMMITTEE ON AGING'S
PUBLIC HEARING
SEPTEMBER 21, 1979

MEMBERS OF THE COMMITTEE:

THE SOUTH CAROLINA COMMISSION ON AGING WOULD FIRST LIKE TO THANK THE COMMITTEE FOR ALL IT HAS ACCOMPLISHED ON BEHALF OF THE OLDER PEOPLE OF SOUTH CAROLINA DURING THE TEN YEARS IN WHICH IT HAS EXISTED.

THE COMMITTEE HAS COMPILED AN UNUSUAL RECORD OF SUCCESSES IN HAVING PASSED LEGISLATION WHICH IT HAS SUGGESTED AND SPONSORED. THE 1979 SESSION OF THE GENERAL ASSEMBLY WAS NO EXCEPTION; ALMOST EVERY ONE OF THE COMMITTEE'S LEGISLATIVE PRIORITIES RECEIVED FAVORABLE TREATMENT BY THE ASSEMBLY. FOR ALL OF YOUR WORK AND CONCERN WE AT THE COMMISSION, AND ALL OLDER SOUTH CAROLINIANS, ARE GRATEFUL, AS WE ARE TO EVERY INDIVIDUAL MEMBER OF THE LEGISLATURE WHO HAS SUPPORTED THE CAUSE OF OLDER CITIZENS.

TODAY THE COMMISSION ON AGING WOULD LIKE TO MAKE SEVERAL SUGGESTIONS, BUT BEFORE I CALL ON OUR DIRECTOR, MR. HARRY BRYAN, TO DO THAT, I CALL THE COMMITTEE'S ATTENTION TO THE FACT THAT FOR THE FISCAL YEAR 1980-81, AMENDMENTS TO THE OLDER AMERICANS ACT REQUIRE AN INCREASE IN THE LEVEL OF NON-FEDERAL MATCHING FUNDS FROM 10% TO 15% FOR NUTRITION AND SOCIAL SERVICES PROVIDED UNDER THE ACT. THE AMENDMENTS FURTHER SPECIFY THAT THIS ADDITIONAL 5% MUST COME FROM <u>STATE</u> SOURCES, IN CASH. THIS WILL REQUIRE AN ADDITIONAL STATE APPROPRIATION TO THE COMMISSION ON AGING OF $330,175. SERVICES PROVIDED THROUGH THESE PROGRAMS HELP OLDER

PERSONS REMAIN IN THEIR OWN HOMES AND COMMUNITIES AS LONG AS POSSIBLE, RATHER THAN BE UNNECESSARILY OR PREMATURELY PLACED IN NURSING HOMES OR OTHER INSTITUTIONS; WE THEREFORE VIEW THIS ADDITIONAL APPROPRIATION AS ESSENTIAL TO THE CONTINUATION OF THE COMMISSION'S MISSION, AND URGE YOU TO HELP OBTAIN THIS AMOUNT DURING THE COMING LEGISLATIVE SESSION.

AND NOW I WILL ASK MR. HARRY BRYAN TO MAKE SOME SUGGESTIONS FOR OTHER LEGISLATIVE ACTION.

Harry R. Bryan, State Director
Commission on Aging
915 Main St.
Columbia, S. C. 29201

Mr. Bryan underscored Dr. Finney's remarks on the need for an additional appropriation in the amount of $330,175. If this amount is not provided, the Commission stands to lose 5-1/2 million dollars in Federal funds.

He then addressed various problems affecting the elderly and offered suggestions which are on the following pages.

After reading his prepared statement, Mr. Bryan said that he was sympathetic to the needs expressed by the spokespersons from Orangeburg and Aiken. It goes back to the comments made earlier by Senator Rubin that money is the answer to a great many of these problems.

Senator Rubin confirmed this and stated that understanding of the financial limitations or realities is necessary on the part of all involved.

There were no questions asked.

REMARKS BY MR. HARRY R. BRYAN, DIRECTOR
SOUTH CAROLINA COMMISSION ON AGING

TO

LEGISLATIVE STUDY COMMITTEE ON AGING'S
PUBLIC HEARING
SEPTEMBER 21, 1979

LET ME UNDERSCORE DR. FINNEY'S REMARKS ABOUT THE NEED FOR AN ADDITIONAL $330,175; WITHOUT THIS, THE COMMISSION, AND THE STATE OF SOUTH CAROLINA, STAND TO LOSE ABOUT FIVE AND ONE-HALF MILLION DOLLARS IN FEDERAL FUNDS.

AND NOW FOR OUR SUGGESTIONS ABOUT OTHER LEGISLATION:

UNIFORM PROBATE CODE. ADOPTION OF THE UNIFORM PROBATE CODE HAS BEEN ADVOCATED FOR SEVERAL YEARS BY A NUMBER OF OLDER PEOPLE'S ORGANIZATIONS IN SOUTH CAROLINA. SETTLEMENT OF ESTATES OFTEN FALLS TO ELDERLY PERSONS, AND THE FACT THAT THE CODE MAKES POSSIBLE LESS COMPLICATED PROCEDURES AND LOWER COSTS APPEALS TO PEOPLE OF THIS AGE GROUP VERY STRONGLY. THE STATE BAR ASSOCIATION AT ITS 1979 CONVENTION APPROVED MOST OF THE CODE; RE-DRAFTING IS NOW IN PROGRESS ON TWO MINOR ISSUES. THE HOUSE OF DELEGATES IS EXPECTED TO APPROVE THE CODE AT A MID-WINTER CONFERENCE; AFTER THIS, THE BAR WILL ATTEMPT TO HAVE LEGISLATION FOR ITS ADOPTION INTRODUCED IN THE GENERAL ASSEMBLY. YOUR CONTINUED INTEREST IN THIS NEEDED LEGISLATION IS URGED.

REGULATION OF SALE OF MEDICARE SUPPLEMENT, OR "MEDI-GAP", INSURANCE.

A WIDESPREAD PROBLEM AMONG SOUTH CAROLINA'S ELDERLY IS THE PURCHASE OF HEALTH INSURANCE TO SUPPLEMENT MEDICARE COVERAGE. CONFUSION EXISTS IN THE MINDS OF THESE ELDERLY CONSUMERS AS TO

WHICH POLICY CAN BEST PROVIDE THE PROTECTION THAT THEY NEED. IN ADDITION, QUESTIONABLE TRADE PRACTICES HAVE ARISEN IN THE SALE OF THIS TYPE OF INSURANCE. THE COMMISSION ON AGING HAS DISCOVERED INSTANCES WHERE ELDERLY PERSONS HAVE PURCHASED UP TO A DOZEN SUPPLEMENTAL POLICIES THAT LARGELY DUPLICATE EACH OTHER'S COVERAGE. SOME OLDER PERSONS ARE NOT INFORMED THAT SOME OF THESE POLICIES CONTAIN WAITING PERIOD PROVISIONS OR EXCLUSIONS FROM PRE-EXISTING INFIRMITIES. SOME AGENTS HAVE REPRESENTED TO THEIR CUSTOMERS THAT THEY WERE PURCHASING ONE TYPE OF POLICY WHEN IN FACT THEY WERE SOLD ANOTHER. BECAUSE AN AGENT'S PREMIUM IS HIGHER FOR THE FIRST YEAR OF COVERAGE THAN IN SUBSEQUENT YEARS, SOME OLDER PERSONS HAVE BEEN PERSUADED BY UNSCRUPULOUS AGENTS TO PURCHASE NEW POLICIES EACH YEAR.

IN ORDER TO PUT AN END TO THESE PRACTICES AND TO INSURE THAT THE CONSUMER CAN MAKE AN INFORMED CHOICE, THE DEPARTMENT OF INSURANCE HAS DRAFTED A SET OF PROPOSED REGULATIONS. THESE REGULATIONS CONTAIN STERN PROHIBITIONS AND INCLUDE STRICT DISCLOSURE REQUIREMENTS. THE COMMISSION ON AGING STRONGLY SUPPORTS THESE PROPOSED REGULATIONS AND HOPES THIS COMMITTEE WILL USE ITS INFLUENCE TO SEE THAT THEY ARE SPEEDILY PUT INTO EFFECT.

THE PROTECTIVE SERVICES ACT AND THE CLIENT PATIENT ACT.

THESE LAWS ARE BOTH IMPORTANT PIECES OF LEGISLATION. AN AMBIGUITY EXISTS, HOWEVER, BETWEEN THE REPORTING REQUIREMENTS OF THE TWO ACTS. THE PROTECTIVE SERVICES ACT DIRECTS PRACTITIONERS OF THE HEALING ARTS TO REPORT ANY CASES OF APPARENT ABUSE, NEGLECT OR EXPLOITATION TO THE COUNTY DEPARTMENT OF SOCIAL SERVICES OR TO THE COUNTY SHERIFF OR CHIEF COUNTY LAW ENFORCEMENT OFFICER IN THE COUNTY IN WHICH THE ABUSE IS BELIEVED TO HAVE OCCURRED. ON THE

OTHER HAND, THE CLIENT PATIENT ACT DIRECTS THESE PERSONS TO REPORT ABUSE TO THE SOUTH CAROLINA LAW ENFORCEMENT DIVISION, THE NURSING HOME OMBUDSMAN, OR TO THE SOLICITOR. CONFUSION IS PRESENT BOTH AT THE STATE AGENCY LEVEL AND AMONG THOSE WHO ARE REQUIRED TO REPORT ABUSE AS TO WHICH STATE OR COUNTY OFFICER OR AGENCY SHOULD HANDLE INVESTIGATIONS OF THIS TYPE. THE COMMISSION ON AGING STRONGLY URGES THE GENERAL ASSEMBLY TO CLEAR UP THIS AMBIGUITY.

COMMUNITY LONG TERM CARE PROJECT.

THE COMMUNITY LONG TERM CARE PROJECT, ESTABLISHED IN CHEROKEE, SPARTANBURG, AND UNION COUNTIES TO EXPLORE BETTER METHODS OF HEALTH CARE DELIVERY TO THE FRAIL ELDERLY AND MAINTAIN THEM IN THEIR HOMES OR COMMUNITIES RATHER THAN PLACING THEM IN INSTITUTIONS, IS OFF TO A GOOD START. SINCE IT WENT INTO ACTION IN JULY, ITS ASSESSMENT TEAM HAS SCREENED APPROXIMATELY ONE HUNDRED PERSONS, AND AN EVEN LARGER GROUP OF PERSONS REFERRED TO THE PROJECT ARE AWAITING ATTENTION. CONTINUED SUPPORT OF THIS PROJECT BY THE LEGISLATURE IS NEEDED FOR IT TO COMPLETE ITS VALUABLE THREE YEAR PERIOD OF SERIVCE AND INFORMATION-GATHERING.

LONG TERM CARE DIVISION IN DEPARTMENT OF MENTAL HEALTH.

THE LEGISLATURE HAS ALREADY DIRECTED THE DEPARTMENT OF MENTAL HEALTH TO ESTABLISH A DIVISION OF LONG TERM CARE, TO DEAL WITH THE PROBLEMS OF THE ELDERLY AND OTHERS IN SITUATIONS INVOLVING PROLONGED INSTITUTIONALIZATION under its care. WE URGE YOU TO SUPPORT THE MENTAL HEALTH DEPARTMENT'S REQUEST FOR FUNDS TO EMPLOY SOMEONE TO SUCCEED DR. THOMAS G. FAISON, WHO HAS RETIRED, AS HEAD OF THIS DIVISION.

ENERGY LEGISLATION.

WITH SKYROCKETING COSTS OF HEATING OIL AND OTHER FUEL AND ENERGY, RELIEF IS NEEDED BY THE FIXED-INCOME ELDERLY, AMONG OTHERS. VARIOUS

PLANS HAVE BEEN TRIED IN OTHER STATES, INCLUDING NORTH CAROLINA, WHERE SPECIAL RATE SCHEDULES HAVE BEEN SET UP FOR QUALIFIED RECIPIENTS OF SUPPLEMENTAL SECURITY INCOME. WE URGE THIS COMMITTEE TO STUDY THE POSSIBILITIES FOR A PLAN WHICH WOULD ADDRESS THIS PROBLEM IN SOUTH CAROLINA.

HOMESTEAD TAX EXEMPTION ACT.

IMPROVEMENTS HAVE BEEN CONTINUALLY MADE IN THE HOMESTEAD TAX EXEMPTION ACT, GIVING ELDERLY HOMEOWNERS A TAX BREAK OF TEN MILLION DOLLARS OR MORE EACH YEAR. THERE IS OPPORTUNITY FOR FURTHER BROADENING, HOWEVER. THE COMMITTEE HAS IN THE PAST GIVEN SOME CONSIDERATION TO RELIEF FOR ELDERLY PERSONS WHO RENT THEIR DWELLINGS; WE SUGGEST THAT YOU TAKE ANOTHER LOOK AT THIS CONCEPT.

ANOTHER CHANGE WHICH WOULD BENEFIT A CONSIDERABLE NUMBER OF PERSONS WOULD BE TO EXTEND ELIGIBILITY TO PERSONS OTHER THAN HUSBAND AND WIFE, WHO OWN PROPERTY JOINTLY, BUT WHO ARE NOT ALL OVER 65 YEARS OF AGE. SPOUSES OWNING PROPERTY JOINTLY ARE NOW ELIGIBLE IF ONLY ONE HAS REACHED THAT MAGIC AGE; BROTHERS AND SISTERS, FOR EXAMPLE, ARE NOT ELIGIBLE UNLESS BOTH (OR ALL) ARE 65 OR OLDER.

USE OF SCHOOL BUSES TO TRANSPORT THE ELDERLY.

PROPOSALS WHICH WOULD PERMIT THE USE OF SCHOOL BUSES TO TRANSPORT THE ELDERLY, WHEN THE VEHICLES WERE NOT IN USE FOR SCHOOL PUPILS, HAVE SURFACED FROM TIME TO TIME. THE LATEST, H-2412, HAS BEEN STUDIED, AND THE SENATE EDUCATION COMMITTEE HAS GIVEN SOME CONSIDERATION TO SETTING UP A PILOT PROJECT. WE THINK THIS IDEA HAS MERIT, AND WE SUPPORT IT.

OTHER PROPOSALS.

IN THE INTEREST OF TIME, WE WILL ONLY MENTION BRIEFLY THAT THE COMMISSION STILL SUPPORTS THE NATURAL DEATH BILL; THAT WE ARE AWARE

OF STUDIES IN OTHER STATES THAT DEAL WITH AID FOR ELDERLY VICTIMS OF CRIME, OR PROPOSE HEAVIER PENALTIES AGAINST PERSONS WHO COMMIT CRIMES AGAINST THE ELDERLY; AND THAT WE ARE INTERESTED IN THE LEGISLATION PROPOSED BY REPRESENTATIVE PATRICK HARRIS AND OTHERS WHICH WOULD ABOLISH THE REAL ESTATE PROPERTY TAX ON HOMES VALUED AT $50,000, WITH AN ACCOMPANYING BOOST IN SALES TAXES. WE CAUTION CARE IN THIS LAST, LEST THE INCREASE IN SALES TAXES DO MORE HARM TO THE ELDERLY THAN THE TAX EXEMPTION WOULD DO GOOD. WE WILL STOP THERE, BUT WILL BE GLAD TO RESPOND TO ANY QUESTIONS THE COMMITTEE MIGHT HAVE. WE APPRECIATE THE OPPORTUNITY TO PRESENT THESE SUGGESTIONS.

Mel Melton
S. C. State Housing Authority
2221 Devine St., Suite 540
Columbia, S. C. 29205

Mr. Melton spoke on the availability of housing for the State's elderly. At the present time, the Authority is participating in multi-family construction, but they are mandating that 25 percent of the units be designed for the elderly. Technical assistance is provided to any community or group desiring to pursue a housing project for the elderly. To date housing has been provided for more than 200 elderly families, and they anticipate that 150 apartments for the elderly will be constructed within the next 18 months.

Senator Rubin wanted to know if the bond issue of approximately 171 million dollars was going forward and whether the program is being undertaken by the Housing Authority.

Mr. Melton confirmed this and told the Committee that this is under the single family program; however, the data to determine how many of the units may have involved financing for senior citizens was not available at the moment as they are going over to computersand to retrieve the information they would have to go through each loan application. The first bond issue constituted about 2,200 loans.

Senator Rubin told Mr. Melton that the Committee would appreciate some information as to the prospects of elderly families being considered under this program. "With such a vast amount of money becoming available, it would appear that an appreciable amount could accrue to the elderly," Senator Rubin said.

There were no questions asked by members of the Committee.

REMARKS TO THE SOUTH CAROLINA LEGISLATIVE STUDY COMMITTEE ON AGING

SEPTEMBER 21, 1979

MR. CHAIRMAN AND COMMITTEE MEMBERS:

SINCE 1972, THE SOUTH CAROLINA STATE HOUSING AUTHORITY HAS PLACED EMPHASIS UPON HOUSING FOR OUR STATE'S ELDERLY.

THE FIRST MULTIFACILITY DEVELOPED WITH ASSISTANCE BY THE AUTHORITY WAS FOR 24 APARTMENTS IN MCCORMICK.

IN THE ENSUING YEARS, WE HAVE BEEN INSTRUMENTAL IN THE CONSTRUCTION OF RENTAL APARTMENTS TO ACCOMMODATE SENIOR CITIZENS IN WALHALLA, INMAN, LANDRUM, COWPENS, BLACKSBURG, CLINTON, LORIS, LAKE CITY, ST. GEORGE, WALTERBORO, VARNVILLE AND RIDGELAND. THESE ACTIVITIES HAVE RESULTED WITH LIMITED RESOURCES OF FUNDS UTILIZING AVAILABLE PERMANENT FINANCING BY THE FARMERS HOME ADMINISTRATION AND RENTAL SUPPLEMENT BY THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT. PRIMARILY, THE RENTS ARE STRUCTURED FOR 25% OF ELDERLY MONTHLY INCOME TOWARD RENTAL CONTRIBUTION.

AT THE PRESENT TIME, THE AUTHORITY IS PARTICIPATING IN MULTIFAMILY CONSTRUCTION, BUT WE ARE MANDATING THAT 25% OF THE UNITS BE DESIGNED FOR THE ELDERLY.

WE HAVE, IN THE PAST, ENLISTED SUPPORT FROM NATIONAL NON-PROFIT ORGANIZATIONS FOR MINIMAL LEVELS OF "FRONT END" FUNDING, BUT THESE SOURCES ARE NOW NON-EXISTENT. I AM HAPPY TO REPORT TO YOU THAT WHEREAS THESE FUNDS WERE OBTAINED, THEY HAVE BEEN REPAID IN THEIR ENTIRETY WITH THE DEVELOPMENT AND CONSTRUCTION OF HOUSING PROJECTS.

THE STATE HOUSING AUTHORITY PROVIDES TECHNICAL ASSISTANCE TO ANY COMMUNITY OR GROUP DESIRING TO PURSUE A HOUSING PROJECT FOR THE ELDERLY. WE WILL ASSIST IN THE ESTABLISHMENT OF A SURVEY PROGRAM TO DETERMINE

THE NEED, SITE SELECTION, STRUCTURING AND FORMULATION OF A NON-PROFIT ORGANIZATION, PROJECT LAYOUT AND DESIGN, FILING OF THE LOAN APPLICATION, CONSTRUCTION RECOMMENDATIONS AND INSPECTIONS, PROJECT MANAGEMENT PLANNING, RELATED SERVICE PLANNING FOR TENANTS, AND COUNSELING FOR OPERATIONS AND MAINTENANCE.

AT THE PRESENT TIME, THE AUTHORITY IS ASSISTING COMMUNITIES OF CLINTON, ST. GEORGE,WALHALLA AND VARNVILLE WITH SUBSEQUENT APPLICATIONS FOR ADDITIONAL ELDERLY RENTAL UNITS.

IT IS THE DESIRE OF THE AUTHORITY TO MAINTAIN A MINIMUM OF THREE APPLICATIONS AT ALL TIMES WITH THE SOLE EMPHASIS ON ELDERLY. HOWEVER, I WANT TO REASSURE YOU THAT ALL MULTIFACILITY DEVELOPMENTS RECEIVING ASSISTANCE BY THE AUTHORITY WILL INCORPORATE A REQUIREMENT THAT A NUMBER OF THE APARTMENTS BE DESIGNATED FOR OUR SENIOR CITIZENS.

IN ORDER TO CONTINUE THE EMPHASIS UPON HOUSING PROJECTS SOLELY FOR ELDERLY, WE NEED TO ESTABLISH A SOURCE OF FUNDS THAT COULD BE DRAWN UPON TO START THE DEVELOPMENT APPLICATION. THE TYPES OF SERVICES WHICH THESE FUNDS WOULD PROVIDE INCLUDE LAND OPTION (NOT PURCHASE), SOIL BORINGS, LAND SURVEYS, AND TOPOGRAPHIC MAPS. FORTUNATELY, WE ARE ABLE TO OBTAIN ARCHITECTURAL SERVICES ON A BASIS OF PAYMENT BEING MADE UPON THE ACCEPTANCE AND CONSTRUCTION OF THESE HOUSING COMMUNITIES. THESE FUNDS WE WILL REQUEST COULD BE REGAINED FROM THE PERMANENT FINANCING BUT THERE IS SOME ELEMENT OF RISK SHOULD AN APPLICATION TO THE FEDERAL AGENCIES NOT BE ACCEPTED FOR CONSTRUCTION. GENERALLY, THE FUNDING FOR SUCH A PROJECT RANGES BETWEEN $5,000 AND $10,000, WITH THESE FUNDS BEING DISTRIBUTED AT DIFFERENT TIMES AND IN DIFFERENT STAGES OF THE APPLICATION PROCESS. THEREFORE, IT WOULD NOT BE ABSOLUTELY NECESSARY THAT ALL OF THE FUNDS BE RISKED. IN MOST CASES, THE GREATEST RISK WOULD BE APPROXIMATELY $2,000.

WE WILL, IN THE VERY NEAR FUTURE, REQUEST THAT OUR COMMISSIONER'S APPROVE A REVOLVING LOAN FUND FOR "FRONT END" EXPENDITURES IN AN AMOUNT OF $15,000 TO FACILITATE DEVELOPMENT OF MULTIRENTAL HOUSING. SUCH AN APPROPRIATION WILL PROVIDE INTEREST FREE LOANS TO COMMUNITIES WITH THE EXPRESSED CONSENT THAT REPAYMENT BE MADE AT THE INITIAL CLOSING OF THE PERMANENT LOAN.

WE ARE PLEASED TO REPORT THAT OUR EFFORTS TO DATE HAVE PROVIDED HOUSING FOR MORE THAN 200 ELDERLY FAMILIES. ANOTHER 64 ELDERLY FAMILIES WILL BE HOUSED BY PROJECTS PRESENTLY IN APPLICATION PROCESSING.

THE FUTURE LOOKS MUCH BRIGHTER WITH THE AUTHORITY IN THE MIDST OF ITS INAUGURAL MULTIFACILITY FINANCE PROGRAM. WE ANTICIPATE 150 ELDERLY APARTMENTS TO BE CONSTRUCTED IN THE NEXT EIGHTEEN (18) MONTHS.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE. IF I DO NOT HAVE THE EXACT ANSWER, I'LL GET IT TO YOU.

ON BEHALF OF THE STATE HOUSING AUTHORITY, I APPRECIATE YOUR ATTENTION AND THANK YOU.

# # #

Harold G. Dye
983 Nabors Drive
Charleston, S. C. 29412

Mr. Dye spoke on the problems caused by rising medical and hospital costs, preventive health care and the need for homemaker services or "home care aides" as he called them. He also touched on the need for Adult Day Care Centers.

Mr. Dye's testimony is on the following pages.

No questions were asked by the members of the Committee.

Date: Sept. 21, 1979.

To: South Carolina Committee to Study Services, Programs and Facilities for Aging.

From: Harold G. Dye, 983 Nabors Drive, Charleston, S.C. 29412
A representative of the AARP on the NRTA-AARP Joint State Legislative Committee.

Both personally and as a representative of the AARP membership in South Carolina, I am concerned that all the elderly of our State receive the necessary aid to make their declining years as comfortable and rewarding as is possible. At the same time, as a tax paying citizen of the state, I am also very concerned that government expenses are held at a manageable level, and that the state is maintained in a financially sound condition. I feel that both goals are compatible with each other.

Medical and hospital costs are among the greatest threats and fears of our elderly, who are often desperately trying to balance a budget in these days of skyrocketing inflation, coupled with a too small fixed income. Better preventative health care can be a big factor in keeping both of these health costs down; and it is my feeling that all of us must greatly increase our efforts in improving both our knowledge and our methods of controlling such debilitating illnesses of our elderly as cardiac-vascular problems, lung problems including emphysema and pneumonia, crippling arthritis, and problems of improper diet. This year our Medical University at Charleston has set up a chair for geriatrics, and we can hope it will be properly funded and the knowledge that is found through studies in that department are quickly disseminated among the medical practitioners of our state. More must be done in both the prevention and the treatment of these crippling diseases among our elderly.

Too many elderly are sent to hospitals needlessly, costing them and/or the government money. Many tests made after hospitalization could just as well have been done in a doctor's office, or at least in a clinic, at considerable saving in cost. Then elderly are being kept too long in hospitals; often because there are no nursing home beds at that time available - and the cost of the hospital stay in twice that of the nursing home. Up to 25% of the beds in our nursing homes are being occupied by elderly patients who would prefer and could live in their own homes, or in the homes of a close relative, if only help could be provided for them there. Such help, if available, would be roughly half as costly as maintaining them in a skilled nursing home. Such help could be handled in two ways.

First, to maintain these elderly in their own homes, there should be available to them trained, live in, "Home Care Aides", who would be available to do the housekeeping chores, plus taking care of the personal needs of the elderly person. Such "Home Care Aides"

would be a God-send to hundreds of South Carolina elderly and frightened people, who long to stay in their own familiar homes, but just can no longer manage things alone. In the older days there were unemployed relatives or neighbors to do just this sort of a thing. Not now available, they see as the only alternative, securing admission to an elderly nursing home, where too often they are lonely and most unhappy. The cost of such livein "Home Care Aides" would be but 1/2 or 1/3rd of a bed and care in any nursing home. Training for these "Home Care Aides" could be given in any of our 2 yr. colleges, with little additional cost to the state. It would also boost employment.

There are others in the nursing homes who have been put there by relatives - sons and daughters who would dearly like to care for them, but because all the adults in the family are working, there is no one left to provide the care. Much the same problem faces them with their own children, but for them there are many hundreds of good Day Care Centers. For their elderly parents, only recently have we had any such centers, and they have almost all been started in the low income areas, where the people never could have afforded nursing home care. We must have more such Day Care Centers for our elderly, centers for all classes, and then publicize them so that both elderly and their close relatives will know of them, and what they can do for their loved ones. The son, the daughter, can drop off the elderly parent in the morning, knowing she will be well cared for during the day, and in congenial company, then on the way home in the afternoon pick her up. Week ends she could provide total care. The cost about a third of a nursing home care, and usually a happier elderly parent.

If South Carolina Social Services Department, and/or Comission for the Aging would push for just these two opportunities for the care of their ~~elderlyxand~~ partially active elderly, there would be enough beds right now in our nursing homes for those who need them, without the long waiting periods now necessary. Our hospitals would be able to reduce their patient load, so further costly additions might not be necessary. The cost to the elderly of our state, to their families, and to the tax payers who must pay so much of the institutional cost through Medicare and Medicaid, would certainly be less. Lets hope a good start can be made to implement some of this in 1980.

W. J. Castine, Chairman
South Carolina Retired Educators Association
3519 Raven Hill Road
Columbia, S. C. 29204

Mr. Castine thanked the Committee and the General Assembly for the excellent work done for the aging. He said that there are many aging in the State whose status is much better due to the Committee's efforts and work.

His testimony contained suggestions for an annual cost-of-living increase of "at least 4 percent" in retirement benefits. He urged implementation of the proviso in the 1979 Appropriation Bill that effective July 1, 1980, the State pay hospitalization/medical insurance costs for retired State employees and teachers. He stressed the need for containment of health care costs and asked that the question of joint ownership (other than husband and wife) of a home be studied.

Mr. Castine's testimony follows.

Mr. Barksdale asked Mr. Castine if he was aware that under the current State retirement procedure if the beneficiary named predeceases, the money goes back to the State. Would Mr. Castine support changing this to naming an alternate or optional beneficiary?

Mr. Castine replied that he can not speak for the organization at this time as this particular situation has not been discussed by the membership; however, he assured Mr. Barksdale that they will take this under consideration as this suggestion seems to be deserving of attention.

THE SOUTH CAROLINA RETIRED EDUCATORS ASSOCIATION

Legislative Proposals to the South Carolina Study Committee on Aging

Prepared and presented to the Study Committee
by W. J. Castine, Chairman, SCREA Legislative Committee -
September 21, 1979

There is little or no legislation that applies only to retired educators. We are members of the South Carolina Retirement System, and are keenly interested in all legislation that affects that system. We will, therefore, establish priorities and work for any legislation that we feel will benefit both retirees and active members of the retirement system.

Inflation continues to threaten and reduce the buying power of persons on fixed income. Many retirees are finding it increasingly difficult to maintain the standard of living to which they have become accustomed. Indeed, there are many who find it difficult to provide the necessities of life for themselves. And the cost of living continues to rise. Therefore, we recommend that legislation be enacted to provide for an annual cost of living increase of at least 4 per cent in retirement benefits, and that this increase be funded through the retirement system so that it is assured each year.* (Insert below)

The 1979 General Appropriations Act contains a provision effective July 1, 1980, for the State to pay hospitalization - medical insurance costs for retired state employees and teachers. This will give relief to a great many retirees, and will enable some who now have no health insurance to be covered. Therefore, we urge that this proviso be fully implemented.

Retired educators are also members of the much larger and growing group of older citizens of South Carolina. Therefore, we are vitally interested in all legislation which benefits or promotes the welfare of the elderly in our State.

* I have said "at least 4 per cent". This will not be adequate if inflation continues at such a rapid rate. However, if this amount could be built into the system it would give retirees some degree of assurance.

Legislation passed, and some that was introduced but not passed, in the 1979 session of the General Assembly is indicative that legislators and the public are becoming more aware of the problems facing South Carolina's senior citizens. Many are faced with difficulties which they cannot handle alone. They need help. We urge the General Assembly to enact legislation that will enable many of these older citizens to cope with their problems and to be less dependent on more costly programs.

Perhaps one of the most urgent areas is that of health care costs. It is essential that some means be found to contain these costs.

Several improvements were made in the area of homestead exemptions. The 1979 Appropriations Act contains a proviso increasing the exemption from $12,000 to $15,000 commencing July 1, 1980. We urge that this proviso be fully implemented.

We commend the Study Committee on Aging for the excellent contributions you are making to older South Carolinians. We express to you our appreciation for the leadership you have given to the State in dealing with the problems of the aging, and we pledge to you our support in your further efforts in our behalf.

We further recommend that the question of joint ownership be studied. In the case of joint ownership by two sisters, one over 65, the other not yet 65, there is no allowed exemption. It seems that the older sister should have the right to claim her share of the exemption. Such situations should be studied to determine what can be done to alleviate apparent inequities.

Lillian M. McCreight, Acting Project Director
Community Long Term Care
P. O. Box 1520
Columbia, S. C. 29202

Mrs. McCreight read her prepared statement which is on the following pages.

Senator Rubin asked if progress of this Project is being unduly delayed by the official absence of the waiver or can they manage satisfactorily until approval is received.

The only thing that would be delayed would be the development of any new services to fill the gaps, replied Mrs. McCreight. "Certainly it has not kept us from being busy about the work of what kinds of things can we do without the waiver. The Community Advisory Committees in each of the project counties have worked intensively with us. It has helped us identify not just agency sources for providing for long term care needs, but what are certain churches in the community doing and what are certain civic clubs willing to do. And those things we are already trying to mobilize—ways with which we can address some of these needs without additional kinds of governmental funding."

COMMUNITY LONG TERM CARE
P. O. BOX 1520
COLUMBIA, S. C. 29202
PHONE (803) 758-2921

Testimony For Public Hearing

Joint Legislative Committee on Aging

September 21, 1979 - 2:30 p.m.

Lillian M. McCreight, Acting Project Director

The Community Long Term Care Project was mandated by the Legislature in the 1978 Appropriations Act to conduct a Pilot Project of community based services for chronically ill and impaired adults in Cherokee, Spartanburg, and Union Counties. The underlying purpose of the pilot is to provide sound data on the needs of the functually impaired population and alternative approaches for meeting those needs for use in statewide policy decisions. The project has completed a period of planning and development of a proposal for Medicare and Medicaid waivers that would enable expansion of community services and remove some of the regulatory barriers to those services. Notice of HEW's decision on the proposal is expected by the end of this month. We have had encouraging feedback from our contacts in Washington and expect the proposal to be approved.

Since July 1, 1979, the project staff has been accepting referrals for assessment of needs and arranging appropriate services. Our best estimates were that 100 referrals/mon would allow the project to contact the bulk of the suspected population in need. Through September 14, a total of 206 persons have been referred to the project from the following sources:

80 hospital social services	12 Nursing Homes	2 Doctors
57 DSS	7 Relatives	1 Veterans Adm.
42 Council on Aging	5 DHEC	

Cooperation of agencies, hospitals, nursing homes, community advisory committees and individuals in the project area has been outstanding. Many referrals have been duplicated by several sources.

Of the referrals, 93 have been assessed by the staff with the following results:

63 nursing homes (some short term plans)
22 remain at home (4 moved out of project area to live with family)
1 refused assessment (all clients are informed about project and give consent before assessment is done)
1 boarding home
6 died

The large proportion going to Nursing Homes can be partly explained by two factors:

1) Initial priority was given to persons in the hospitals waiting for Nursing Home beds -- because this is the most expensive place to wait -- this group is the sickest population and those most likely to need 24 hour care.

2) In the beginning the project was confronted with a backlog of persons and families who had exhausted their resources -- physical, emotional, and financial -- for coping at home. A decision for Nursing Home care was already made and in some cases, a bed was available and an ambulance waiting. The prospect of changing the decision at that point was very unlikely.

Although the total numbers of people who are being maintained at home is not impressive this early in the project, there are several examples of project involvement making a real difference. One is a family who had the mother's name on a Nursing Home waiting list because the father, who has the main responsibility for her care, is in poor health. The adult children feared he would not be able to continue functioning under the stress of providing a significant amount of daily care for his wife. Her name came to the top of the Nursing Home waiting list and the decision became an urgent one - should we take this scarce bed while its available or should we continue at home while things are o.k.? The project staff worked with the client and her family to identify supports and with the Nursing Home on flexibility in accepting this person at a later date if the family situation changes. The outcome was that the lady is still at home and the husband is doing well. We're counting successes case by case at this point -- and the excitment is that any situation in which the best possible

arrangements for care are made to meet the persons' needs -- whether at home or in an institutuion -- is a success. The gaps in community services that are most readily evident at this point are personal care or companion (someone to be with the patient for blocs of several hours or all day) and arrangement for meals.

There is another aspect of the project work I would like to share. In planning for individuals we have identified a number of systems problems -- problems generating from the way we have designed our health and social services in the state and from policy decisions in the past.

A few examples include:

1) A local agency on aging experienced difficulty in finding sitters among the active older population for a patient for two weeks following a hospitalization even with a way to pay because the temporary increase in the sitter's income would affect eligibility for Food Stamps and, in the process of redocumentation of eligibility, persons would very likely experience a gap in access to an adequate food supply.
2) The intended "solution" of dual-certified Nursing Home beds for the problem of moving patients about creates a financial incentive to fill beds with patients with less impairment and care needs, leaving the patients requiring more care in hospitals. (Happily, many Nursing Homes administrators do not yield to such temptation, and the project assessment process is a safeguard in this area).
3) Under current regulations a Nursing Home or hospital wanting to maximize the use of its resources by providing medical day care would have to undergo two licensing processes and could only accept day care participants who are mobile. They would also have to have separate space for inpatient and day care, thus missing the social benefit of interaction between these groups.

4) In seeking mental health assistance for a family in a potentially explosive situation -- a paralyzed, aphasic mother who is demanding, a distraught and exhausted spouse, a pair of daughters who are helping and are intensely angry with four siblings who are not helping - we encountered the policy of having persons come into the clinic for help. The policy is based on sound concepts. Philosophically, a person must want and seek help to benefit from it -- and economically -- dependence upon services that can be reimbursed by Medicaid, but families with problems such as I've described will not be reached. (The Waiver application attempts to relieve this problem).

5) Aging meals programs with a 15% limit on home delivered meals serve a very different population from the frail, ill, house-confined group we are addressing.

6) If a hospital patient no longer needs acute care and no Nursing Home bed is available, he must be classified as "skilled" for the hospital to continue to be paid for his care. If a decision is made that the level of care is less than skilled, hospital income stops. Most long term care patients waiting in hospitals are certified as "skilled", but when transferred to a Nursing Home are determined ICF by PSRO review. This well known phenomenon has been named the "ambulance cure" by frustrated Nursing Home administrators. (Due to PSRO review average LOS in hospital per Medicaid payment continues to decline).

These examples are not shared with the intention that you produce quick legislative solutions but to illustrate the complexity of arriving at the "right" solution. Each policy has good reasoning to back it up -- but touches off an adverse consequence in another place. The recognition of the interrelationships of the systems that are involved in long term care and the organization of the Long Term Care Policy Council to struggle with these interagency large systems problems is one of the most positive innovations I have encountered in examining long term care interventions nationwide. You would be proud of the intensity of interest and the openness and candor of the discussions of the agency heads represented on the Council. Alternative policy solutions to the problems I cited

are already being sought with the assurance that the new solutions won't create new problems because of a lack of awareness or understanding.
(An example of the openness is their willingness to let me talk about these sticky issues in this open forum).

Thank you for letting me share where we are in these early days of Community Long Term Care Project. We will continue to communicate as we work toward providing people real options for meeting long term care needs.

Dr. Robert K. Moxon, President
S. C. Society of Internal Medicine
Columbia, S. C.

Dr. Moxon did not have a prepared statement. He addressed his remarks to S-161, the Natural Death Act. He said he was astonished at seeing the amount of opposition to this Bill, principally by people motivated on purely emotional issues; people who obviously have not read the bill and people who ordinarily, he would suspect, would react rationally to a well thought out, carefully researched and organized bill. Anyone who has been in the practice of medicine any length of time—and Dr. Moxon has been in practice for 35 years—have seen people whose lives have been prolonged unnecessarily painfully, expensively and sometimes horribly by artificial means to no use or purpose whatever.

Dr. Betty Mandell
S. C. Gerontological Society
P. O. Box 6443
Columbia, S. C. 29260

Dr. Mandell spoke on the history and the purpose of the Gerontological Society. Her prepared statement, which she read, is on the following pages.

Senator Rubin commended Dr. Mandell's efforts. What will be achieved in the future depends entirely on public education. He is looking forward to working with the legislative committee of the Society, which will be created this next year.

Remarks Before the Legislative Study Committee on Aging by Betty Mandell SCGS

Senator Rubin, Committee Members;

The South Carolina Gerontological Society was formed in the spring and summer of 1978. It was incorporated as an eleemosynary organization on October 25, 1978. The purposes of the society are;

1. To initiate, stimulate and encourage action in promoting or developing facilities and/or programs to meet the needs of older people.
2. To act as a medium for communication and to afford a common meeting ground for everyone concerned with the field of aging.
3. To work cooperatively with any group, organization or individual in expanding service programs, education and research in the field of aging.
4. To encourage interest of the general public in the field of aging and promote awareness of the needs, rights and continuing contributions of older people.
5. To increase scientific knowledge in gerontology.

At the first annyal meeting in October of 1978, I was honored to become the first President of the society. Harry Bryan, of the S. C. Commission on Aging is the Vice President, Mirium Patterson, the A A A Director of Greenwood, is the Secretary and Pat Rowe with the Red Cross in Charleston is Treasurer. These people and many others have worked hard. The Society has had a very successful first year. The membership rolls now number 340 and include direct service providers, academic gerontologists, agency personel and doctors and nurses. A regular newsletter has circulated. We have included in the newsletters and will continue to include the legislative up-date supplied to us by Ms. Keller Bumgardner. We do this to keep the membership informed about legislative issues.

Planned for the second annual meeting include Dr. Nelson Cruikshank, the Presidential Advisor on Aging, as our keynote speaker and Dr. Ellen Winston as our Banquet speaker. The Society does extend, to anyone who shares the goals of the Society, an invitation to join the Society and to attend the Annual Meeting.

I am giving you the history and makeup of the society because I want you to have some awareness of the energy and activity that support this organization from a diversity of persons who are connected by their interests and concerns in aging.

I know that the purpose of this hearing is to serve as part of the legislative process of information gathering. We have not had an active legislative committee this first year. However, In this next year, the society will have an active legislative committee and this committee has as its chairperson, Ruth Denny of the College of Nursing at USC. Ruth Denny will introduce the members of her committee. The purpose of this committee will be to educate the membership in greater depth about issues before the legislature, and to help keep The Study Committee on Aging informed about problems and concerns of the membership that are amemable to legislative correction.

I would like at this time to commend the Study Committee on Aging on its legislative priorities of the 1979-80 session and to congratulate the members for the successes in putting into the Appropriations Bill the advances in the quality of life for the elderly persons of South Carolina in Housing, Health, Recreation, Retirement and also for presentation of the National Death Act.

I appreciate being placed on the schedule for today and I want to particularly thank Keller Bumgardner for keeping us informed and for doing such a good job. Its an honor to come before the Study Committee. Thank you.

Dr. Racine D. Brown, Deputy Commissioner
Planned Systems Change
Department of Mental Health
P. O. Box 485
Columbia, S. C. 29202

Dr. Brown gave a status report on the Long Term Care Facility which this Committee was instrumental in getting authorized in 1975.

He voiced his concern on the increasing admissions to Crafts-Farrow State Hospital and the budget cut of $400,000 during the Appropriation Bill process in the '79 session. The Department will have to request a deficiency appropriation to restore these funds.

Another matter of great concern is the transporting of patients back to counties of residence for multiple hearings. This is especially hard for elderly patients. He urges to change this statutory requirement.

Dr. Brown's testimony is on the following pages.

South Carolina Department of Mental Health
An Equal Opportunity Employer

P.O. Box 485 / 2414 Bull Street / Columbia, South Carolina 29202 / (803) 758-8090

William S. Hall, M.D.
State Commissioner of Mental Health

TESTIMONY BEFORE THE
STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
SEPTEMBER 21, 1979

PRESENTED BY
RACINE D. BROWN, PH. D.
DEPUTY COMMISSIONER, PLANNED SYSTEMS CHANGE
FOR THE
S. C. STATE DEPARTMENT OF MENTAL HEALTH

MR. CHAIRMAN AND OTHER HONORABLE MEMBERS OF THE COMMITTEE, I APPRECIATE THE OPPORTUNITY TO APPEAR REPRESENTING THE STATE DEPARTMENT OF MENTAL HEALTH. I WILL SPEAK ABOUT SEVERAL MATTERS WHICH HAVE BEEN OF LONG STANDING INTEREST TO THE DEPARTMENT AND TO THIS COMMITTEE.

FIRST, I WANT TO GIVE YOU A STATUS REPORT ON THE LONG TERM CARE FACILITY WHICH THIS COMMITTEE WAS SALIENTLY INSTRUMENTAL IN GETTING AUTHORIZED IN 1975. YOU WILL RECALL THAT FUNDING FOR A 300 BED LTC FACILITY WAS INCLUDED IN THE STATE BONDING BILL OF THAT YEAR. SUBSEQUENTLY, THE PROJECT WAS INCLUDED IN A FREEZE ON CAPITAL PROJECTS IN THE STATE BONDING PROGRAM. IN THE 1978 APPROPRIATIONS ACT THE DEPARTMENT WAS AUTHORIZED, HOWEVER, TO CONDUCT THE ARCHITECTURAL/ ENGINEERING STUDIES PERTINENT TO THE 300 BED LTC PROJECT. THE PLANS ARE NOW VIRTUALLY COMPLETED FOR THE NEW FACILITY, 308 BEDS, TO BE LOCATED ON THE C. M. TUCKER, JR. HUMAN RESOURCES CENTER CAMPUS. THE DEPARTMENT EXPECTS TO BE SEEKING AUTHORIZATION TO CONSTRUCT THE FACILITY WITHIN THE NEXT SEVERAL MONTHS. WHEN COMPLETED, THE 308 LTC BEDS WILL BE UTILIZED PRIMARILY FOR PATIENTS THEN IN CRAFTS-FARROW STATE HOSPITAL FOR WHOM THE LTC FACILITY REPRESENTS THE MORE APPROPRIATE LEVEL OF CARE.

I turn now to speak about Crafts-Farrow State Hospital per se. As with the other psychiatric hospitals, the number of admissions to Crafts-Farrow continues to increase. Since 1976 the annual number has increased from 826 to 1,016, an increase of 190 people. Significantly, 182 of these are people ages 65 and over. The percentage of admissions ages 65 and older has increased by nine percent in the last three years, now standing at 57%. The resident population age 65 and over has increased, in that period from 56.5% to 61.2%. The daily census has been inching upward in recent months.

The Crafts-Farrow budget picture for FY 79-80 is predictably inadequate. During the appropriations process in the '79 General Assembly, the Crafts-Farrow budget was cut by $400,000 while the Bill was in the Conference Committee. It is a certainty that the Department will have to request a deficiency appropriation for restoration of those funds (as well as $450,000 which were likewise cut from the S. C. State Hospital budget) in order to maintain services for the current year.

The third matter I want to call to your attention is that of the necessity, under the current statutory requirements, for transporting patients back to counties of residence for multiple hearings. The Commissioner of Mental Health and other Department spokesmen have previously discussed the hardship this procedure frequently works on patients. We are particularly concerned about the difficulty it represents for the elderly patient. With almost five years experience with the current statutes, we are most interested in persuing in-depth study of the matter with the relevant participants toward the end of effecting whatever procedural changes are feasible to reduce the unfavorable aspects of the current process.

LASTLY, I WANT TO INDICATE ENTHUSIASTIC SUPPORT FOR THE COMMUNITY LONG TERM CARE PROJECT FROM THE DEPARTMENT OF MENTAL HEALTH. WE EXPECT TO BE FULL PARTNERS IN THE PROJECT IMPLEMENTATION, AND IN THE LEARNING PROCESS DERIVED THEREFROM.

AGAIN, MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO APPEAR.

Harry Joe King, President
Home Health Services, Inc.
Charleston, S. C.

Mr. King was unable to attend the Hearing personally. Mrs. Nan Hazelwood, a registered nurse and paramedical supervisor of Home Health Services, Inc., read Mr. King's statement to the Committee after making a few introductory remarks herself which concerned home health services.

Mr. King's statement addressed itself mainly to availability of more private, non-profit services as well as State services and asked for cooperation of all the agencies.

Mr. Chairman, Ladies and Gentlemen:

My name is Nan Hzelwood. I am a registered nurse and employed at Home Health Services, Inc. the only private, non-profit agency providing Home Health care in the state. As Paramedical Supervisor, I work with registered nurses, physical therapists, occupational therapits, speech therapists, and medical social workers. As health professionals, we are surprised to find the needs we see among the elderly. Serving patients in Charleston, Berkeley and Dorchester counties, we are made aware daily of the number of persons, 65 and older for whom health care is inadequate.

It concerns us that South Carolinians live fewer years than natives of other states. We feel it is absolutely necessary that all providers of health care work together in order to supply better care for all individuals in the state. No one organization can do the job alone. Hospital and nursing homes must provide skilled care. For many individuals, however, home health services can provide the intermittent skilled care needed. We have found among our patients the desire to remain at home and independent as long as possible. By providing them with the care they need, we can help them maintain their independence and also help to keep the cost of health care down.

Respectfully,

Nan Hazelwood, RN

Nan Hazelwood, RN

Mr. Chairman, Ladies and Gentlemen:

Due to the last minute change in my scheduled appearance before your honorable committee which created a conflict with my quarterly Advisory Board Meeting, I am having Mrs. Nan Hazelwood, who is a registered nurse and paramedical supervisor in our private, non-profit Home Health Agency to deliver this paper on my behalf. To quote the Annual Implementation Plan of Palmetto Low Country Health Systems Agency submitted to HEW for federal grant funds, "life expectancy for South Carolinians is a bleak statistic. The stark truth is, on the average, death knocks at the doors of people in South Carolina sooner than any other state in the nation. ...Life expectancy in South Carolina is ranked 50th in the nation." We live 2.8 years less than the national average in South Carolina. In the 12 low country counties of HSA IV, life expectancy drops even more by an average of 1.4 years. This plight on behalf of all South Carolinians is pathetic indeed.

Home Health Services may be defined as a complex of services which may be brought into the home singly or in combination in order to achieve and sustain an optimum state of health, activity and independence for individuals of all ages. The Social Security Administration Act (Title XVIII) allows for the provision of part-time intermittent nursing care, physical, occupational or speech therapy, social work and nutrition services to home-bound patients. Home health services are a feasible alternative to institutionalization in terms of cost, efficiency and a way of life for the client. Home Health services can be considerably less expensive than care in a hospital or skilled nursing care facility. Home health services can prevent premature institutionalization or allow early release of an institutionalized patient resulting in a decrease of unnecessary patient days and a cost-savings. The literature reflects that older people would prefer to go on living in their own home where possible and Home Health Services allows that opportunity.

In accordance with the chart on Page V-155, Home Health Services provided by County Health Departments S.C. HSA IV, FY 1976 shows the total percent of home health needs met by DHEC county health department programs for South Carolina as a whole was 41%. For the Trident District, which is the area served by our Agency, only 31.3% of the needs were met. This means less than one-third of our grandmothers and grandfathers in need and entitled by law to these benefits were being served. The following most recent statistics made available to us indicated that the Trident area had increased by 1.3% of needs met to a total of 32.6% still less than one-third of those in need being served. The state total at this point had increased from 41% to 49%, still less than half the needs being met on a statewide basis in our state where per capita income ranks 48th in the nation and life expectancy ranks 50th in the nation. In the Geriatric Care Study revised August 14, 1979 by Palmetto Low Country Health Systems Agency, the percent of the 1977 elderly population in South Carolina being served in all Health Service Areas and Health Districts in the state was only 5.1% of the total population of senior citizens being served by the Department of Health and Environmental Control. "The availability of adequate home health services can reduce the number of hospital admission or readmissions. These services also provide continuity of care following a patient's release from a short- or long-term care facility and may also allow for earlier discharge of the patient's from these institutions."

In the News and Courier on Sunday, August 20, 1978, there was an article which read as follows: "Next to Washington, D.C., South Carolina is the unhealthiest place in the country. Proportionately, more people die of cancer, heart disease, pulmonary ailments, hypertension, stroke, diabetes, kidney infection, accidents and homicides in South Carolina than in the nation as a whole. The state is above the national average in the occurence of communicable diseases, including tuberculosis, venereal disease, meningitis, German measles, Rocky Mountain spotted fever and many chronic diseases as well." As one state official put it: "In terms of statistics, we are an unhealthy state." Ladies and Gentlemen, I beseech you again as I did in Charleston at your last regional meeting when I was allowed to address this honorable committee, please consider that if we in South Carolina are to be successful in our efforts to improve the quality of health care, we must not continue to dwell only on past performance of state and local health care agencies. Many of these agencies have become so defensive that they are fast becoming even more non-productive. State and county health care providers must face the reality of the enclosed statistics and join in a spirit of cooperation and coordination on behalf of all South Carolinians and particularly the pathetic plight of our senior citizens.

Respectfully,

Harry Joe King,
President

HJK/emd

Summary

P-LHSA Health Systems Plan

Life expectancy for South Carolinians is a bleak statistic.

The stark truth is, on the average, death knocks at the doors of people in South Carolina sooner than in any other state in the nation, except the District of Columbia. Translated into numbers, state residents live an average of 68 years — 2.8 years less than the national average. Life expectancy in South Carolina is ranked 50th in the nation.

In the 12-county Palmetto-Lowcountry Health Service Area IV, life expectancy drops even lower to an average of 66.6 years. A break down of that figure shows the life expectation for white females in the area is 74.8 years and 67.0 years for nonwhite females. The figures stand at 66.1 years for white males and 58.3 years for nonwhite males. Infants less than one year old and people 65 and older have the highest death rates.

The Palmetto-Lowcountry Health Systems Plan is the tool by which the Palmetto-Lowcountry Health Systems Agency is proposing over a five-year period to attack the conditions which breed such statistics. It is a plan which outlines the improvements necessary to better the health status of area residents and the health systems that serve them. Each year the plan will be revised and republished as required by law. As conditions change, the plan is expected to change.

Given the ten leading causes of death in HSA IV — heart disease, malignant neoplasms, cerebrovascular diseases, accidents, influenza and pneumonia, diabetes mellitus, other diseases of the circulatory system, mortality in early infancy, homicide and suicide — nonwhites in the area have a higher fatality rate than whites do in all but three categories.

Figures show the fatality rates for whites are greater only in the categories of heart diseases, other diseases of the circulatory system and suicides.

The difference in the race specific rates is attributed to documented evidence that low socioeconomic status is associated with a higher incidence of disease. In HSA IV, the median income for whites is more than double that for nonwhites.

Health Status and Systems Goals

A health status goal of the HSP is to reduce the rate of heart disease deaths, the leading cause of deaths in the area, from 256.3 to 230 per 100,000 population by 1982.

To accomplish this, the plan recommends implementation of a public education program to inform the public of risk factors which increase susceptibility to heart disease, extensive hypertension screening with referrals, and urges hospitals to work together to provide efficiently operating cardiac care units.

It suggests that comprehensive cancer screening programs be available to the public by 1980 in order that its goal to reduce cancer-caused deaths from 125.1 to 110 deaths per 100,000 population or less by 1982 is achieved.

Further, the plan recommends strict enforcement of the Occupational and Safety Health Act regulations to decrease accidental deaths. The rate for such deaths is 63.2 per 100,000 population in HSA IV and 57.6 per 100,000 population in the state.

In addition, accidents account for 13.7 percent more deaths per 100,000 population in HSA IV than the national rate.

Passive passenger restraints in all new cars by 1982 is recommended as well as vigorous enforcement by the South Carolina Highway Patrol of the 55 mph speed limit and of penalties for driving under the influence of drugs and alcohol.

Consumer education programs are urged to instruct parents on how to safeguard their homes to prevent accidental poisionings or injury to children.

The plan encourages immunization programs aimed at the very young and the elderly, and an investigation this year into the potential for increased use of midwives and appropriate training programs for expectant mothers.

Data from the S. C. Department of Health and Environmental Control indicate that county health departments are not meeting the need for maternal services within their counties. HSP favors development of a comprehensive system for maternal care in the area and the elimination of the difference in the infant mortality rate for the white and nonwhite populations by 1982.

The plan, developed over the past year by the P-LHSA Board of Directors, Plan Development Committee and the HSA IV community, additionally supports:

— Cardiovascular, renal, cancer and glaucoma screening clinics throughout treatment centers in HSA IV.

Alternatives to Institutionalization (cont.)

Home Health Services - Home Health Services may be defined as a complex of services which may be brought into the home singly or in combinations in order to achieve and sustain an optimum state of health, activity and independence for individuals of all ages. In this section, discussion on home health care will be restricted to periodically required medical, nursing or therapeutic services which either prevent premature institutionalization or allow early release of an institutionalized client into a place of residence. Home health services provision of medicare is the major source of payment for home health services. The Social Security Act (Title XVIII) allows for the provision of part-time intermittent nursing care, physical, occupational or speech therapy, social work and nutrition services to home-bound patients.

Home health services are a feasible alternative to institutionalization in terms of cost, efficiency and a way of life for the client. Home health services can be considerably less expensive than care in a hospital or skilled nursing care facility. Home health services can prevent premature institutionalization or allow early release of an institutionalized patient resulting in a decrease of unnecessary patient days and a cost-savings. The literature reflects that older people would prefer to go on living in their own homes where possible and Home Health Services allow that opportunity.

The major concern expressed in this section is the need to insure that people are able to obtain home health services that are consistent with their particular needs. It is recognized that achievement of this goal will require a delivery system which has flexibility in allowing movement from one level of care to another, has an adequate supply of services from meeting identified needs, and has effective controls to insure uniform quality of care. The present and potential influence of reimbursement in molding the present health system to meet these goals has been identified in this chapter where relevant.

Realizing that hospitals and nursing homes are indispensible for those who are seriously ill and require extensive treatment, a balanced delivery system which includes home health services should provide an alternative for the many people who do not require that level of care. In Health Service Area IV, home health services are being provided in conjunction with the county health departments, community health centers and a private, nonprofit agency (Home Health Services, Inc.) located in Charleston, South Carolina.

In addition, Certification of Need and Section 1122 review for the establishment of Home Health Services by a private, nonprofit organization are not required due to the lack of nationally accepted standards and criteria for the review of

Alternatives to Institutionalization (cont.)

home-based services. The Department of Social Services through the process Certification for Medicaid participation has the only review authority for such services in the area.

Home Health Services, as presented, considers the population in need of home health care and deals with services and facilities which are the usual providers of this care. Persons considered are those receiving care and persons in need of care, but who are not under care, such as persons with chronic illnesses (as defined by the National Center for Health Statistics) and physical and emotional disabilities which prevent them from performing normal daily activities for the self-administration of necessary medical treatments.

Palmetto-Lowcountry Health Systems Agency recognizes the contribution of Home Health Services to providing a balanced delivery system for the residents of the area and encourages further development of these services.

P-LHSA further recognizes that Certification of Need, Section 1122, or other review mechanisms, are needed to insure adequate planning and allocation of home health services throughout this area, the state and country.

Community Health Centers - Community health centers as previously discussed are seen as a viable alternative to institutionalization. The community health centers concentrate on providing and coordinating comprehensive, continuous, family-oriented high quality primary health care, at reasonable cost in a community-based setting acceptable to consumers with their participation in matter of program policy.

Community health centers, through their staff and supporting resources, provide: (1) continuous comprehensive primary health services; (2) supplemental health services necessary for the adequate support of primary health services; (3) referrals to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services; (4) environmental health services, for particular community health centers; (5) information on the availability and proper use of health services for residents of the area it serves.

There are four community health centers operating in Health Service Area IV of South Carolina:

- Franklin C. Fetter Family Health Center, Inc., Charleston
- Sea Island Comprehensive Health Care Corp., Johns Island
- Orangeburg County Consumer Health Council, Orangeburg
- Beaufort-Jasper Comprehensive Health Services, Inc., Ridgeland

The total registered patients among the above community health centers range from 5,000 to 20,000.

Home Health (cont.)

services in fiscal year 1974) and approximately 3,258 persons in S.C. HSA IV in 1976. (The following chart indicates the number of persons served in each district within S.C. HSA IV, the percent of need met, and indicates the percent of change in the number served.)

HOME HEALTH SERVICES PROVIDED BY COUNTY HEALTH DEPARTMENTS
S.C. HSA IV, FY 1976
(Number of Persons Served and Percentage of Need Met)

District	No. in Need	No. Served	% Need Met
Lower Savannah	2,999	1,710	57.0
Trident	3,389	1,218	31.3
Lowcountry	1,370	805	58.8
S.C. Total	34,346	14,294	41.0

Source: 97th Annual Report of S.C. DHEC, FY 1976

HHS, INC. AREA 4/5/77

Generally, the components of home health care in South Carolina include skilled nursing, home health aide/homemaker, physical therapy, medical social services, speech therapy, occupational therapy and dietary services. All of these services except dietary services are available to a varying degree in S.C. HSA IV (see chart, next page). The Social Research Institute of the University of South Carolina estimates that less than one-third of the people who could benefit from these services are now being reached.

The availability of adequate home health services can reduce the number of hospital admissions or readmissions. These services also provide continuity of care following a patient's release from a short- or long-term care facility and may also allow for earlier discharge of the patients from these institutions.

Home health care services can have a significant impact on the elderly, the handicapped and the chronically- or acutely-ill person. Community based health services can be instrumental in providing the necessary support to prevent premature institutionalization. These services are also less costly than institutionalization. Patients quite often prefer home care to institutionalization; thus, they may be more responsive to treatment. Home health services can also reduce the burden on physicians in the area by using other health personnel to provide elementary health services.

10-B The Evening Post, Thur., February 1, 1979
Charleston, S.C.

Study Recommends Medical Schools Emphasize Elderly

BOSTON (AP) — Medical schools are not spending enough time teaching new doctors how to care for old people, a report of the National Academy of Sciences concludes.

The study recommends that medical schools put more emphasis on the ills of the elderly in existing medical courses.

It also suggests that schools teach a required course in geriatrics and make sure residency programs expose young doctors to old people in nursing homes and day care centers.

The study, directed by Dr. Peter E. Dans of Johns Hopkins Hospital in Baltimore, was prepared at the request of the federal National Institute on Aging. A condensed version of the report was published in today's New England Journal of Medicine.

The report recommended that more money be spent on research about aging, but it rejected a proposal that some doctors specialize in geriatrics.

"Given contemporary society's fascination with youth and the unwillingness for individuals to deal with their own mortality, it is not surprising to hear in university hospitals terms like 'old crock' and 'gomer,' an ironic mocking of future selves," the report said. "Such negative attitudes are detrimental to the training of physicians who will take care of so many elderly...."

The study noted that 11 percent of Americans are over 65, and about 30 percent of the nation's health care budget is spent on them.

SUNDAY/ The News and Courier
THE EVENING POST

August 20, 1978

Plan In Works To Fight S.C. Health Woes

By CLIFF FOSTER
Staff Reporter

Next to Washington, D.C., South Carolina is the unhealthiest place in the country.

Proportionately, more people die of cancer, heart disease, pulmonary ailments, hypertension, stroke, diabetes, kidney infection, accidents and homicides in South Carolina than in the nation as a whole.

The state is above the national average in the occurrence of communicable diseases, including tuberculosis, venereal disease, hepatitis, German measles, Rocky Mountain spotted fever and many chronic diseases as well.

As one state official put it: "In terms of statistics, we are an unhealthy state."

Now, a major effort is under way to change those statistics and bring the death and illness rates in South Carolina closer to the national average.

Under the guidance of the State Health Planning and Development Agency, a five-year plan is in the works to combat the most serious health problems by directing health care dollars where they are needed most. The plan is supposed to resolve health problems by promoting equal access to quality health care at a reasonable cost.

The state health plan is the offspring of the National Health Planning and Resources Development Act of 1974, a federal law designed to make the states responsible for health planning and to give consumers a voice in federally financed health care programs. The act created local Health Systems Agencies which are responsible for planning and development in their respective regions and a Statewide Health Coordinating Council to advise the agency responsible for the health planning activities in the state.

Unlike other health planning laws before it, the 1974 act invests unprecedented power at the state level, particularly in the SHCC. In South Carolina, the SHCC is made up of 68 members appointed by Gov. James B. Edwards in October 1976. When the state health plan is adopted in September, SHCC will use it to influence health policy and to guide the expenditure of millions of federal health care dollars.

The act requires state health agencies seeking funds from the Department of Health, Education and Welfare to have their plans approved by the SHCC. If the SHCC disapproves the plan, the state agency must change it or successfully appeal the decision to HEW before federal dollars are released.

The South Carolina plan reflects the goals and priorities of the five HSAs in the state as well as the suggestions of state health and health related agencies. A six member planning team began writing the plan after the last HSA plan was approved this winter and finished it in late May. The 569 page document is available in county libraries and will be the subject of public hearings across the state on Aug. 28, including one at the Palmetto Low-county Health Systems Agency, 167 West 6th North Street, Summerville. After the hearing the SHCC will review the plan and formally adopt it sometime in September.

The plan includes a statistical profile of health problems in the state and an inventory of services provided by South Carolina's health care systems. It suggests improvements in health care delivery in order to bring the incidence of death and disease closer to the national averages.

"We hope to use the health status (See Page 8C, Column 1)

-100-

Plan

Continued From Page 1-C

Another problem is that the state health plan could be rendered meaningless if it is vetoed. Local HSAs are already planning for next year, but the state health plan reflects goals they cited more than a year ago. State health planners point out that the planning process is a continuing one and the plan will be updated as HSA plans are approved.

"Once this thing gets rolling the whole thing will feed on itself," said Linda Shigimoto, bureau chief for the state health planning division. "The Health Systems Agencies' plans will feed into the state health plan and in turn the state health plan will feed back into the health systems plan."

But even though the local plans generally match up with the state plan there is still a potential for conflict. What happens, for instance, when the state plan recommends a certain action that conflicts with the local plan? "That's the question that has a lot of lawyers at HEW wondering," Sugimoto said. "At this point there is no mechanism worked out to deal with that."

Despite these and other problems, local and state health planners are optimistic. "In time I think the two documents (the local and state plans) will be very consistent with one another," said Scott of the PHSA. "Both agencies are very young and are searching out a role for each other. We really don't know exactly what that role is right now."

e state health plan is divided health status goals a nd health ts goals.

wide, the top health status goal reduction of the infant mortali- by 11.8 percent, from the 1976 of 19.5 infant deaths per 1,000 births to 15.6 deaths per 1,000. national average is 15.1 infant s per 1,000 live births. Other call for the reduction of the ity rates for heart disease, ant neoplasms (cancer), cer- vascular disease, accidents and ction in the incidence of chron- d communicable diseases.

meet those goals the plan sug- improvements in health care y systems. As a top priority, ls for new mechanisms to make y health care services availa- all South Carolinians, particu- those who live in rural areas also suggests that maternal ild health services be made ble to mothers who need them, ase should be educated about and referred to ecular diseases, family planning services be available to men and women want them, that all citizens be ected against communicable es which can be controlled gh immunization and that ef- be made to promote the early tion of cancer.

plan also considers individual s submitted by local HSAs last

e the incidence of disease and availability of services varies gion to region, the plan pin- where money should be spent programs established to meet health needs of health systems of the HSAs. "One of the things done is identified where in the the problems are occurring," Walcott Cokley, director of ate health planning division. s puts them (the HSA) on notice a developing resources they or eople that are involved should to deliver the problem."

ny of the state's health prob- are centered in HSA III, the Dee region north of Berkeley ty. This is because it is largely a area where services are not as sible or sophisticated as in the of the state.

situation is not as severe in IV, the 12-County Lowcounty The plan suggests that ef- s made to reduce the accident ity rate, the mortality rate d cerebrosis and the incidence d disease. HSA IV health sys- goals for the region call for ements in the drinking water n fluoridation, better health n programs, mass immuni- ns against infectious diseases, a ensive dental program for n, emergency dental serv- amily planning services, ma- and infant care services, screening programs and the utilization of facilities and ded treatments.

Health planners are not en- ncouraged with the draft plan and to voice their concerns to the health planners. The seven- tions regarding HSA IV were in the HSA plan but to ... concerns ... areas of ... development for the Palmetto ... Health Systems Agency ... the priorities are all ad- ... but it is not clear that they ... priority wanted to

Mildred S. Townsend, Coordinator
Charleston Area Senior Citizens
Services, Inc.
P. O. Box 343
Charleston, S. C. 29402

Mrs. Townsend read her statement to the Committee. Her remarks dealt with the Medically Needy Program.

(Additional material handed in by Mrs. Townsend is on file in the Committee).

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CHARLESTON AREA SENIOR CITIZENS SERVICES, INC.

September 17, 1979

State of South Carolina

Study Committee on Aging

Petition: "Medical Needy Program"

Submitted By: Mildred S. Townsend
Coordinator, Senior Citizens Services, Inc., Charleston, S. C.

In my work I am closely associated with many Senior Citizens. I find that the persons on Social Security and their income is a little over the required amount to qualify for S.S.I., and has high medical expenses, especially medication, is the most needy. If there was some way that the S.S.I. could have a little flexibility, without creating another monster, it would make such a difference in many lives.

Why could it not be possible that if a person had $35.00 or $50.00 a month especially in Rx drugs (just using this amount as an example)could he or she apply for S.S.I. as the custom is now? Have proof that her medical expenses met this figure, or what ever figure was decided upon.

Could it not be done without more people being hired. I certainly am not capable of writing a bill or an amendment, but it seems that only one additional question would not necessitate the hiring of additional staff. Only one amendment would have to be made to the law now in existence at this time. I am aware that S.S.I. branches off from Social Security but S.S.I. is funded by the State with Federal help and different States have a different interpretation.

If it is not possible to act on this petition at state level, then we have no state rights.

Respectfully Submitted by

Mildred S. Townsend

Dr. Julius E. Hammett
S. C. Federation of Older Americans
S. C. State Employee Association
Richland-Lexington Council on Aging
Columbia, S. C.

Dr. Hammett read his statement; it is on the following pages.

Main points in the testimony dealt with:

1. Homestead Tax Exemptions
2. Rising health care costs
3. Cost-of-living increases for State retirees

There were no questions asked of Dr. Hammett.

Report at the Hearing of the South Carolina Legislative Committee on Aging - September 21, 1979

Mr. Chairman and other members of the South Carolina State Study Committee on Aging, I appreciate the priviledge of appearing before you. Your committee has made extensive studies on the needs and value of the aging population. This committee has made sound and comprehensive recommendations to the Legislature. The Legislature has recognized the value of the findings of this committee, both to the state and its citizens, and has passed legislation which is bringing about great progress for the aging in South Carolina. I want to personally commend you on your wisdom and devotion to this cause.

I am deeply involved in the aging movement and have the honor of serving at the present time on the boards of three voluntary organizations. These are the South Carolina Federation of Older Americans, the South Carolina State Employees Association, and the Richland-Lexington Council on Aging.

HOMESTEAD EXEMPTIONS

In 1970 -'71 I served as president of the South Carolina Federation of Older Americans. The Federation, along with the South Carolina State Commission on Aging, sponsored the first Homestead Tax Exemption proposal to the study committee. This study committee introduced and saw passed the first Homestead Tax Exemption Bill in the Legislature with an exemption of $5,000 per home. The study committee worked faithfully for the first $5,000 Homestead Exemption and has continued to work toward increasing the appropriations. The goal for 1980 is $15,000. This Homestead Exemption Act has made it possible for the aging to continue to live in their own homes.

HEALTH

Health care is becoming a real problem with inflation continuing to rise and we do not seem to have the right answers. I think the health proposals are in the right direction.

RETIREMENT

South Carolina retirees are indeed grateful for the additional 2% increase sponsored by the study committee. This entitles retirees to a 6% cost of living. This boosts the morale as well as the economic condition of retirees. A person who retired eight years or even before that has lost better than 50% of his buying power in the present market.

We retirees would like to recommend to the study committee that both short and long range plans be proposed which will protect our buying power. This probably could be done by adoption of a floating escalation clause which would not jeopardize the solvency of the retirement system. Rampant inflation in recent years has had a devastating financial impact on countless retired South Carolinians living on fixed incomes. I want to state that runaway costs are the primary concerns of most older people today.

In closing I wish to say that the aging people in South Carolina are most grateful to this committee for its outstanding achievements in the aging field. We pledge our support to this committee and the total legislative and administrative branches of our government in helping to make our state the greatest in the nation.

Presented by Julius E. Hammett

Reverend Marvin Lare, Coordinator
Community Care, Inc.
1611 Devonshire St.
Columbia, S. C. 29204

Reverend Lare's testimony is on the following pages.

He spoke on the following points:

Tax incentives for home care.

State tax deductions for documented mileage in registered programs of volunteer service supporting the elderly.

Insurance coverage for volunteers using their own automobiles for transportation of elderly persons. They would like to see a greater exploration of safeguards and greater provision for clarification protection for persons who transport elderlies in their cars.

Another area, related to volunteer companionship, deals with stipends. In the Federal Title XX regulations there is no prohibition to providing stipends for volunteers; however, in our State guide lines and regulations, we do not permit payment as a reimbursable cost of stipends to volunteers. Other states do permit it and Reverend Lare feels this should be changed.

Representative Evatt informed Reverend Lare that there are two national insurance policies at a cost of $3 per year to cover insurance for volunteers.

Senator Rubin referred to Mr. Lare's remarks concerning the prohibition of stipends for volunteers. He asked him to explain and added that there is no prohibition against paying them if you have the money.

Reverend Lare said that under Title XX stipends for volunteers is not an allowable cost for reimbursement in South Carolina. It is acceptable in the Federal regulation and many states do provide stipends under Title XX as a reimbursable cost. However, because of the particular way that the Title XX contract is drawn up in this State between the Department of Social Services and DHEC stipends are not reimbursable.

Representative Evatt suggested to put this in writing to Mr. Milton Kimpson, Chairman of the Title XX Advisory Board to DSS.

Senator Rubin wondered if that would have the effect of taking some... of their available funds from their primary purpose to the use of stipends.

Reverend Lare answered that this issue was just not raised or included in the current contract.

Representative Barksdale asked Reverend Lare what he thought of granting tax credits to volunteers.

Reverend Lare said that he would encourage exploration of this suggestion.

Senator Rubin added that volunteers are absolutely essential to our overall efforts and that this has been brought up a good bit at this Hearing.

Community Care INCORPORATED

The Reverend Marvin I. Lare
Coordinator, Community Care, Inc.

September 21, 1979

TESTIMONY BEFORE THE LEGISLATIVE COMMITTEE ON AGING

Senators, Members of the Committee, and Friends:

I would like to share with you this afternoon a number of concerns which Community Care has uncovered in its concern and commitment to the aged of our State -- particularly in the area of natural and informal supports for the aging which have been of particular interest and concern to our board and high priority ever since we initiated the Meals on Wheels Program in this area.

Seeking to follow that concern with a number of other logical developments, we have developed two programs from which we draw some recommendations and suggestions for you today. The first of these is a Caregiver's Research Project for which we have secured funding from the national level of the Episcopal Church, the Presiding Bishop's Fund, to do research among those who are providing care for infirmed elderly persons. The second of the projects of which I'll speak is the Companionship Program, Volunteers' Companionship Program, for which we have secured support this year under a contract from DSS under Title 20.

The first project: In doing research among caregivers, we have completed interviews with 160 persons in the Great Columbia Area who are carin g for in their own homes or in adjacent homes parents, husbands, close friends, or relatives in which they are the primary support for these persons' day to day care and sustenance. These persons we find from this study are doing so with virtually no help or assistance from any existing agencies. While many agencies have focused on the impaired elderly in various of their needs, those persons who are the national supports and caregivers of these persons by and large have been overlooked and are not greatly sustained by our system. Yet, given the alternative, when these caregivers break down or the alternatives to their support of these persons end in institutionalization in nursing homes or convalescent centers, these persons represent a tremendous resource to our community both in the moral, social, and personal as well as the health and medical supports of these persons. So, we are quite concerned that caregivers themselves play such a vital role in our natural part of our society and yet, by and large are doing this with very little if any support of assistance in it.

Therefore, one of the recommendations which I would like for the Committee to explore and which, as we complete and write up in formal report and study of caregivers in some of the pilot activities which we'll carry on among them, that we will make more detailed recommendations on, is that we find that some states such as the state of Florida give special tax incentives to those persons who are caring for infirmed elderly persons in their homes and other than standard deductions at the present time, there are no special resources. But I submit to you that the cost to our community and to the state is much lower to sustain those caregivers than it is to the alternative of institutionalization of the impaired elderly persons which it currently sustains. Our society cannot begin to sustain the burden if all the caregivers or if this national system were to collapse or be greatly undermined, or any further undermined.

Therefore, I suggest while there are a number of things that could be explored in supporting these natural caregivers that tax incentives that would assist them in their support and care of these persons is something that I would like the Committee to explore. We will seek to develop some more specific recommendations including other states in addition to Florida that have legislation in this area.

More specifically in the area of volunteer companionship and the learnings we have just in the early stage of this Title 20 Contract in which we recruit, train, and place volunteers to work with isolated and impaired elderly persons, we find that as we have developed this program that for one thing the incentives for volunteers to assist these persons are rather low in that the federal/state deduction for using their automobile is something like 7¢ a mile whereas we recognize the high cost of transportation in this day and age. Therefore, volunteers are really behind the eight ball when it comes to providing transportation to persons in volunteer programs. And while we recognize the state cannot deal with the federal level, nevertheless, at the state level we would like to see state tax deductions for documented milage in registered programs of volunteer service supporting the elderly. Some increases in this would give added incentives for volunteers to be able to use their cars effectively in this kind of service.

In a related matter, the whole area of insurance coverage as volunteers use their automobiles for transportation of elderly persons of various programs is a very grave area -- something of a no man's land. We would like to see a greater exploration of how some safeguards and perhaps even in the insurance laws and regulations greater provisions for clarifying protection for the person who is carrying a person in their car in a regular program as an active volunteer in our community service programs.

The third area related to Volunteer Companionship and other forms of volunteer service is that in the federal Title 20 regulations themselves there is no prohibition to providing stipends for volunteers. However, in our particular state guidelines and regulations do not permit the payment as a reimburseable cost of stipends to volunteers and we feel that this is a matter that should be changed. Other states do permit it and have had good experience with it. When you compare the hours of service put in by volunteers compared to some modest stipends which would help enable them to free their time and energies and to cover some of the costs which they incur in being a volunteer, I think again this would multiply greatly in incentives for volunteers to become involved with the elderly in our community.

So, this is the gist of my testimony sharing with you today primarily in the area of natural and informal supports for the elderly. We are cooperating quite closely with the Commission on Aging and the area agency on aging and new explorations in this field include coordination of care for the health impaired elderly. We'll share with the committee from time to time specific results or recommendations that we draw from these activities.

Mrs. Randi Olafson, Director
"Seek-A-Senior" Employment Referral Program
Richland-Lexington Council on Aging
1800 Main St., Suite 3-C
Columbia, S. C. 29201

Mrs. Olafson's testimony centered on securing employment for people over 55 and promoting the older worker. The program is funded through CETA (Comprehensing Employment Training Act) and is presently operating on six months United Way of the Midlands emergency funds, to terminate December 30, 1979. It is the only program of its kind in the Southeast.

Contributing to the need for employment of the elderly are many factors, one of these is inflation, social services programs for the elderly are becoming more costly, and the health status is improving.

As with many other speakers, Mrs. Olafson spoke on the lack of transportation for the elderly. Up until now they have relied on transportation being provided by the Richland-Lexington Council on Aging; however, volunteer services have been drastically cut due to lack of monies.

Senator Rubin assured Mrs. Olafson that the Committee is amenable to suggestions and applaud the work by the Richland-Lexington Council on Aging.

There were no questions asked by the Committee.

RLCOA
1800 Main Street - Suite 3-C
Columbia, South Carolina 29201
252-7734

September 21, 1979

RICHLAND-LEXINGTON COUNCIL ON AGING
Fletcher Spigner
Executive Director
Linda Varner
Director, Transportation

REPORT TO LEGISLATIVE STUDY COMMITTEE ON AGING:

PREPARED BY (MRS.) RANDI OLAFSON, DIRECTOR

"SEEK-A-SENIOR" EMPLOYMENT REFERRAL PROGRAM

RICHLAND-LEXINGTON COUNCIL ON AGING

Senator Rubin and honorable Committee Members: My name is Randi Olafson and I'm the Director of the "Seek-A-Senior" Employment Referral program for the Richland-Lexington Council on Aging. The primary goal of this program is to secure employment for persons over 55 and to promote the older worker. In addition, we offer counseling services prior to referral. Since it's inception two years ago, we have counseled more than 800 persons and made 322 job placements. This service is needed and it works!

The Employment Referral program has been funded primarily through the Comprehensive Employment Training Act and is presently operating on six month United Way of the Midlands emergency funds to terminate December 30, 1979.

The "Seek-A-Senior" Program is utilizing many community volunteers to augment its' services: 1. Three University of South Carolina journalism students are helping with public relations, brochures, publicity and graphics.

2. Two Junior League volunteers are doing applicant and placement follow-up.

3. One Voluntary Action Center of the United Way of the Midlands volunteer is recruiting jobs and promoting the older worker.

4. One Voluntary Action Center volunteer, an older American herself, is invaluable to us as a job counselor.

I have been on the job for only two months, but in that brief period, the cries of the older worker have been heard daily in my office. "Randi, I need to be needed again. I don't feel like I'm of any use to anyone. I need a reason to get up in the morning. I feel as though I have no self esteem left. My former self confidence is gone. Please help me regain my identity. My brain is stagnating and I'm tired of depending on others for stimulation and guidance."

The state of the economy is also a significant factor. Hundreds of middle income retirees within our community are quickly becoming poverty level. I look to each of you to consider how you would feel if you had never wanted, <u>really</u> wanted for anything materially. You had a more than adequate income to support yourself and family. You worked hard at it for thirty years and deserve to have that special retirement time without having to worry about the utility bill. Now you find yourself in a food stamp line, an unemployment line, calling social service organizations for help from somewhere - anywhere. What does that do to your pride, your spirit! Think hard how you would feel personally.

Many of our older Americans have told me about their efforts at seeking employment before coming to our agency. They call about a job, give their qualifications and the perspective employer says, "Great! How soon can you be here?" They go for an interview and as soon as they walk in the door, they see the shadow cross the employer's face. They're <u>always</u> pleasant enough as they say, "Oh, <u>I'm sure</u> the hours won't suit you" or "<u>I'm sure</u> the salary is less than what your were expecting." There's <u>another</u> blow to the ego, the steady pealing away of those layers of self confidence built up through the years.

In mid- 1974 there were over four million unemployed or retired persons 65-plus who wanted to work but were unemployed. Another 2.5 million elderly were working full or part-time. The major factors pointing to the need for employment opportunities for the elderly are:

1) Social Security financing problems may limit benefits. Such benefits already are insufficient to meet the basic needs of housing, food, and transportation.
2) Inflation continues to lower purchasing power DAILY.
3) Older persons are changing their self-images and favor continued involvement rather than withdrawal.
4) Levels of education continue to rise.
5) Health status of the elderly is improving.
6) Social Service programs for the elderly are becoming more costly.

In addition, employment of the older American, obviously have a positive impact on unemployment payments, food stamp payments and welfare. Many persons who are receiving social security would rather work full time and pay the extra taxes on their additional income than remain home and stagnate.

We have had many applicants for homemaker, sitters for the elderly, convalescent care, and companion positions thereby reducing governmnet spending in still other areas and providing alternatives to nursing home care.

For every person who comes to our program, there is a different set of circumstances- but the NEED is always the same - "please help me feel like a contributing member of humanity again. Help me find a job."

The vital need of transportation has directly affected the delivery of other services in our agency. Our city has done a fantastic job in providing housing for the elderly -

(ie Marion Street Hi Rise, Finlay House, Christopher Towers, etc.) However, a great majority of these residents can no longer get to their doctors, pharmacies, and grocery stores. They have relied very heavily on the transportation service provided by Richland - Lexington Council on Aging! The hundreds of hours of volunteer services provided by our older Americans has also been drastically reduced due to the lack of transportation. If additional monies were available, the independence of our older Americans would be greatly increased.

It has been my great privilege to speak to such a knowledgeable and responsive group today. Thank you for allowing me to share my thoughts and experiences with you.

Ed Taylor
Route 2, Box 320
Irmo, South Carolina

Mr. Taylor illustrated his remarks by citing two case histories. His statement is on the following page.

Representative Evatt noted that the phone number of the Nursing Home Ombudsman, Mr. Bill Bradley, is not listed in the telephone book. He has discussed this with Mr. Bradley who confirmed this.

PRESENTATION TO S. C. JOINT STUDY COMMITTEE ON AGING,

September 21, 1979

by Ed Taylor, Rt. 2, Box 320, Irmo, S. C. representing Metro Baptist Association; Senior Citizens Groups of Lexington, Chapin and Seven Oaks Recreation Centers.

It is a pleasure to have this opportunity to address the Study Committee on Aging on behalf of several senior citizens groups of Lexington and Richland Counties. There are several issues that I wish to bring to your attention:

(1) Increase Cash Resources - We recommend that the Study Committee on Aging urge our Congressional Delegation to increase from $1500 to $3000 the amount of total cash resources a person can have in order to be eligible for Medicaid and SSI support.

(2) Sales Tax Exemption - Retired citizens on limited set incomes are finding it more difficult to exist. We recommend that consideration be given to removing sales tax for persons 65 years old and over for certain items, especially food purchases.

(3) Day Care for Adults - Many senior citizens are being placed in nursing and boarding homes because their children work, and they cannot be left alone all day long. More Day Care Centers for adults would allow these older citizens an opportunity to support their personal independence and promote their social, physical and emotional well-being. Every community should have these Centers available.

(4) HOMESTEAD EXEMPTION - We appreciate the increased homestead exemptions that have been approved in recent years, but with the sharp rise in property values it is recommended that the homestead exemption in our state be increased to $25,000. Without this increase many of our citizens might lose their homes because they cannot pay increased property tax.

(5) MULTI-PURPOSE CENTERS - We recommend that Multi-Purpose Centers be located in strategic places to provide a place of fellowship for the older generation. These would allow a focal point for the needs of these persons and provide fellowship opportunities.

(6) NURSING HOMES - Although we realize that Nursing Home Ombudsman's Office is doing a good job in checking out complaints of nursing homes, we feel that so many citizens are not aware of this office or its function. We urge this Committee, the S. C. Commission on Aging, local Council on Agings and S. C. Department of Social Services publicize the Nursing Home Ombudsman's function statewide. If this office needs additional staff, we urge that funding be provided.

(7) Transportation - More and more older citizens do not have transportation. More free transportation needs to be provided for these persons, especially in the rural areas. Free ambulance services should be provided to all senior citizens on a need basis. The increased costs of this type service makes it all impossible for persons on limited incomes.

I realize that you have heard these requests before today and many today, but our active groups wanted a voice in government, and we appreciate you allowing us to speak on these issues.

Mrs. Barbara W. Moxon, Chairperson
S. C. Commission on Women
P. O. Box 11467
Columbia, S. C. 29211

Mrs. Moxon's testimony pointed out inequities in social security benefits affecting older women; she urged the Committee to pursue legislation that provides for equitable distribution of property at divorce; spoke on the plight of the displaced homemaker and expressed her hope that the Study Committee on Aging will support the legislation--now in the Senate Finance Committee--which would authorize the Commission on Women to establish a center for displaced homemakers. An appropriation will be necessary to provide for this service. Another area the Committee should give attention to are battered wives.

The Commission expects to put out a regular newsletter with information on programs, laws, resources and facilities of special concern to women. She asked for input from the Committee.

Mr. Evatt informed Mrs. Moxon that there is another bill in the General Assembly which would put the displaced homemaker center under the Department of Social Services. In his opinion, if it were funded under the Commission of Women, it would become another service provider instead of really carrying out the mandate of the law that created the Commission.

Mrs. Moxon replied that they see themselves as meeting the special needs of women and the displaced homemaker is a special woman, and in many states the displaced homemaker centers are established and run by Commissions on Women. "We are not here to try to build up any kind of empire; the important thing is that these needs that we are identifying be met in the best way the State Legislature and those involved see it could be met in the most economical way..."

Senator Rubin added that this was fair enough; to get the job done has to be our attitude on everything.

South Carolina Commission on Women

P. O. BOX 11467, COLUMBIA, S. C. 29211

STATEMENT BEFORE PUBLIC HEARING of S.C. STUDY COMMITTEE ON AGING

Senate Chamber, September 21, 1979

I am Barbara W. Moxon, Chairperson of the S.C. Commission on Women. Our Commission is an 8 year old state "agency" whose function is to study the status of women and their legal treatment in all facets of living, particularly in regard to any discrimination that may exist in any area. We are to make recommendations for change to those governmental leaders who can effect such change and are to disseminate information and materials relating to the rights, responsibilities and status of women. To this end and without any staff, we have done a needs assessment survey of women several years ago, then a study of female vs. male employment in state government, and most recently an analysis of current S.C. laws and procedures which are sex biased. We also now have available five pamphlets on the legal rights of women: WOMEN,WILLS AND ESTATES, WOMEN AND CREDIT, WOMEN, MARRIAGE AND DIVORCE, PARENTAL RIGHTS AND RESPONSIBILITIES, and WOMEN AND PROPERTY RIGHTS. These pamphlets are available to any citizen upon request and are part of a series with more topics to follow.

In trying to meet the special needs of women in our state, we are realizing that the older woman has even more special needs and is even more discriminated against than other women. Eight out of ten women outlive their husbands. On an average a woman can expect to live the last eleven years of her life as a widow. This presents financial hardship in most cases as well as psychological and other problems no doubt discussed by others here today.

Years ago older women had different roles. Many older women today cannot adapt to the changing role of women. They are not prepared to take over full independence which may be thrust upon them. In distributing our first pamphlet on women and wills last spring, we received many letters from older women expressing ignorance in regard to wills and their legal rights of inheritance.

Our needs assessment survey showed women do not know what resources are available to them, especially older women who may not have been much involved in the community. We are hoping to meet this need which I shall explain in my closing.

There exist many inequities in social security benefits affecting older women which we hope that your committee is aware of. We all need to work with the federal government to eliminate these. In this connection we need to recognize the economic value of homemaking in social security benefits. The contributions of women as homemakers in the home should also be considered when it comes to distribution of property at divorce. Many older women are given no share in property in their husband's name in a divorce settlement because their contributions to the marriage were not monetary but in years of service. He may own material goods because his wife managed carefully, sewed clothes for the children, etc. but the law does not take this into consideration. We urge that your committee pursue legislation that provides for equitable distribution of property at divorce where discrimination against the older woman now exists.

The plight of the displaced homemaker, often an older woman, is another area of concern to our Commission. A displaced homemaker is a person, usually a woman, who has devoted her life to homemaking and raising children and suddenly finds her-

 S. C. Comm. on Women

self through separation, divorce or death, without a spouse and insufficient income to support herself. Often these women have no marketable skills. Some do not even know how to apply for a job, prepare a resume, nor how to act in an interview. They do not know what training may be available nor what kind of training they should take. If our definiation of a displaced homemaker places here between the ages of 35 and 62, and many place it younger, they are too young for social security and ineligible for other public benefits. Many are completely overwhelmed by the necessity of managing their own finances, property and insurance, and coping with all the responsibilities of carrying on life alone after having a partner who shared these matters. At the Budget hearings last week. Governor Riley asked particularly that we give attention to this plight of the older woman.

It is estimated that there are over 38,000 displaced homemakers in South Carolina, if they exist here in the same proportion as in the country as a whole. While several of our Tech Schools and a few other agencies have developed programs to help the displaced homemaker, these are only a drop in the bucket compared to the need. Therefore we hope that the Study Committee on Aging will give support to the bill now back in the Senate Finance Committee which would authorize the Commission on Women to establish a center for displaced homemakers. This is strongly backed by our Lt. Governor. Such support should include also the necessity to provide appropriation for this Displaced Homemakers' Center in the State Budget next year.

Battered wives are another segment of our population which is growing and badly in need of help. Currently I only know of a few groups which are attempting to tackle this problem, - the YWCA, the National Organization for Women, and the people at Providence Home. Some churches make referrals, and the Columbia Area Mental Health Center and DSS offer some help. But here again, this is only a drop in the bucket compared to the need. Some officials do not even recognize the problem exists. But believe me, it does, and it includes the older woman as well as the younger. We would ask that you give this problem some attention.

Our Commission will soon be hiring a staff person which will make it possible for us to carry out more programs for women. We expect to put out a regular newsletter with information on programs, laws, resources and facilities of special interest to women. We would welcome the in-put of your Committee in developing this newsletter so that we can be sure to speak to the needs of the older woman. As funds become available we also hope to research, publish and distribute a statewide directory of resources for women's problems with attention to the older woman. We envision working with your Committee, and in fact many if not all of the agencies represented here today, in this endeavor.

We appreciate your Committee's creating a climate of respect for older women, and look forward to our working together in efforts to meet their special needs.

Thank you.

Claude R. Vaughn, Chairman
Legislative Forum
S. C. Federation of Older Americans
P. O. Box 4927
Columbia, S. C. 29240

Mr. Vaughn addressed the following subjects:

1. Tax relief

2. Merger of Federal, State, and other local governmental retirement systems with that of the Social Security Retirement System.

3. Natural Death Act

Senator Rubin asked Mr. Vaughn to explain the request for a Resolution informing Congress of opposition to any merger of the Federal, State and other local governmental retirement systems with that of the Social Security System.

Mr. Vaughn said that it is their understanding that there is a Commission in Washington which is studying the possibility of merging these systems to help keep the Social Security System from "going under." The Federation is very concerned about this merger. He offered input on this subject at a later date.

Senator Rubin thanked Mr. Vaughn for all he has done to support the Committee regarding legislation of mutual interest, especially in the matter of the Natural Death Act.

South Carolina Federation Of Older Americans

A Non-Profit Organization
P. O. Box 4927 / 3601 Chateau Drive / (803) 782-2460
Columbia, South Carolina 29240

September 14, 1979

TO: The Honorable Hyman Rubin,
Chairman, South Carolina Joint
Study Committee on Aging,
Columbia SC 29201

SUBJ: Items for Presentation at Public Hearing - September 21, 1979

Mr. Chairman and other distinguished Members of this Committee, I am Claude R. Vaughn, Chairman of the Legislative Forum of the South Carolina Federation of Older Americans. We, the members of the Legislative Forum representing the several Retired organizations and their membership throughout the State, do appreciate this opportunity to appear and relate to this committee some of the concerns confronting the older citizens of this State.

1. Taxation is increasingly becoming a burden to those who were not priveleged to work in a period of high salaries and retirement opportunities, consequently, it is most difficult for them to compete with inflation, high consumer prices, high cost of medical services, and high cost of taxation. Therefore, we offer the following suggestions for consideration in the deliberations of the 1980 General Assembly:

   a. Initiate and pursue action toward enactment of a law which would grant an additional $800.00 exemption to any citizen of the State upon reaching age sixty two, adding an additional $800.00 exemption, thereafter, at two year intervals.

   b. Consider the possibility of granting a $10,000.00 tax exemption to all tax paying retirees at age sixty two years of age and older, regardless of the retirement system from which they retired.

   c. Support, vigorously, the Bill introduced by Representative Jarvis Klapman, of Lexington County, and others, to exempt the residents of this State from paying property taxes on the homes in which they live, by increasing the general sales taxes of all individuals.

   d. Continue to pursue efforts toward granting higher Homestead Taxes for Older Citizens.

   e. Also, contine the efforts to increase funding for such matters as Home Health Care, Chore Services, Transportation, Nutrition, and improvement in the Standards for Institutional Care.

2. Urge the General Assembly to adopt a resolution informing the Congress and Administration in Washington of your opposition to any merger of the Federal, State, and other local governmental Retirement systems with that of the Social Security Retirement System.

3. We are still vitally interested in the matter of the Natural Death Act of 1979, and ask that this committee again pursue this matter to a final conclusion. We especially appreciate your efforts, as well as other members of this committee who were so diligent and instrumental in guiding S-166 through the deliberations of the Senate to final passage by that body.

4. We pledge to assist you and members of this committee in any way that we can to help bring any fruitful legislation for the benefit of all South Carolinians to reality during the ensuing 1980 deliberations.

Respectfully submitted,

Claude R. Vaughn

CLAUDE R. VAUGHN,
Chairman, Legislative Forum

Linda Lucas, Assistant Professor
College of Librarianship
University of South Carolina
Columbia, S. C.

Professor Lucas' testimony addressed the information needs of the aging and how they can be met. She called the aged the most "information poor" of all disadvantaged groups and emphasized that if the Committee's programs are to be successful, the people who need the services have to know about the services and how to obtain them.

INFORMATION NEEDS OF THE AGING

A Paper Presented to the

South Carolina Study Committee on Aging

September 21, 1979

Prepared by

Linda Lucas, Assistant Professor
College of Librarianship
University of South Carolina at Columbia

INFORMATION NEEDS OF THE AGING

In the Gateway to Great Books it was observed that:

> Amid the uncertainties of life, this much is certain -- whoever lives long enough will grow old. Whoever grows old will first grow older, and whoever lives to sixty or seventy will be old much longer than he is young.

Technically, all of us as aging adults fall within the target group of these hearings, and each of us has information needs related to our own aging process. The focus of this paper, however, will be on the information needs and the information seeking behavior of those who are already aged; that is, those who are in what we usually consider the retirement years.

An understanding of both information needs and information seeking behavior is critical to your success in implementing effective programs of service to the aged. No program can be successful unless the people eligible know of its existence and understand how to obtain its benefits. Since research has shown that the aged are the most "information poor" of all disadvantaged groups, it is clear that special effort must be made to publicize programs intended for them. Librarians, in seeking to better serve their communities, have been active in studying information needs and information seeking behavior. This paper is based to a large extent on the results of such studies. More detailed information may be found in an article by Genevieve Casey called "Library and Information Needs of Aging Americans" which appeared in Library and Information Service Needs of the Nation, a publication of the U.S. Government Printing Office. The summary table for that article is attached to this paper.

To a large extent the information needs of the aged are no different from the information needs of all adults. The aged need to know how to manage their money, how to care for their health, and how to become involved in activities which will give meaning to their lives. However, because society has tended to stereotype the aged as deteriorating individuals who are no longer capable of making meaningful contributions to life, the aged often find themselves without jobs or adequate income, without adequate housing or health care, and without involvement in activities which they have valued throughout their lives. The information needs of the aged, therefore, are quite literally survival needs: needs for information about income and employment, about health care and nutrition, about housing and transportation. Because the aging process so profoundly affects individuals it is important that the aged understand how they can expect the aging process to change them physically and mentally. They will then be better able to distinguish fact from fiction and may even be able to approach old age with less fear. At the very least, they may be able to minimize the unquestioned difficulties which come with old age.

The survival needs of the aged are not only physical in nature, however. Their psychological survival is also threatened. Because our society takes a negative view of aging, the aged are often placed in positions of diminished power irrespective of their actual abilities. The world around them is changing rapidly, and the ideals and values they have held throughout their lives are challenged and changed. It is difficult enough for those of us who are younger to adjust to change. It is even more difficult when the physical effects of aging and the loss of family members and friends through death have weakened the individual's psycholo-

gical support system. It is little wonder that depression is a common problem among the aged. Unfortunately, in our society we tend to equate depression in the aged and the physical changes which result from the aging process with senility. If the individual is aged, it is assumed that he or she cannot be successfully treated for depression or physical illness. It is now possible, however, to successfully treat many of the physical and emotional illnesses commonly associated with old age. Depression in the aged is recognized as a quite normal response to drastic changes in the individual's life, and there is evidence that neither intelligence or memory are diminished by the aging process to the extent that is commonly assumed. The aged need to know that their illnesses can be treated so that they will seek help rather than continuing to suffer. Such information may also serve to reinforce their feelings of self worth. The aged need to know that they can still make contributions to society - and society as well needs such knowledge. To the extent that the aged have learned to successfully adapt to the changes in their lives, they have much to teach those of us who are still learning. They can and should be information givers as well as information seekers.

In satisfying the information needs of the aged we are faced by many barriers. The barriers imposed by physical disabilities such as blindness or confinement to a wheelchair are obvious. It is less obvious that many of the aged have lost their traditional information sources. Most people regardless of age obtain most of their information directly from other people. The aged often find their circle of human contacts greatly reduced. Since they are no longer working, they seldom see former colleagues who regularly provided information. Younger family members may be scattered across the country. Contemporaries, including mates, may have died. Fear

of change and rejection may mean that the individual does not work to establish new relationships; physical impairment may mean that he or she cannot. Consequently, as the aged become more socially isolated, they have fewer opportunities to obtain information from their traditional sources - other people.

This social isolation is the greatest barrier we face in providing information to the aged. If we are to make the aged aware of the services available to them, we must find mechanisms to circumvent the barriers imposed by physical disabilities and social isolation so that we can reach them directly through human contact to the greatest extent possible. A variety of approaches can be used to achieve this goal. The likelihood of reaching people directly is greatly improved if publicity of services as well as the services themselves are focused at the neighborhood level. Aged individuals who are involved in planning services can serve as information givers to publicize and interpret services to their contemporaries in their home neighborhoods. Some publicity should also be directed to family and friends so that they can transmit the information.

Three techniques devised by libraries for direct service to the disadvantaged in their communities can serve as models for reaching the aged directly with information from other agencies. The most used of these techniques is outreach. For many years librarians have literally carried books and other materials to the private homes or institutions where isolated people live. Sometimes deposit collections are placed in institutions and books replaced periodically. A major problem for librarians in establishing effective outreach programs has been the identification of individuals who need the service. It is relatively easy to identify institutions where the aged live; it is difficult to identify the home-

bound. Librarians have used advertising campaigns aimed at the families and friends of the homebound to identify the confined. They have also cooperated with community organizations such as churches to identify potential users of the service.

A second technique for reaching people directly was developed at Detroit Public Library. It is the "walking tour." Pairs of librarians regularly walk through the neighborhoods they serve with the goal of identifying information needs, information resources, and information outlets in those neighborhoods. The librarians talk with the community residents they meet, take note of the locations where people congregate, and observe which individuals are trusted by their peers to give information Through this mechanism people who would not ordinarily think of the library as an information source become familiar with the librarians as information givers. The librarians, in turn, become acquainted with individuals who are in need of the information they can provide as well as with individuals who can transmit that information within the neighborhood. They are also able to identify locations in the neighborhood where posters and other publicity should be placed to reach most people.

Thirdly, in response to needs found in their communities several public libraries, including Detroit Public Library, have developed Information and Referral Centers to serve people directly by telephone. These I and R Centers focus on helping the public, including the aged, to locate information related to their survival needs. The Centers maintain extensive files of telephone numbers and community information so that they can provide information immediately or refer the caller to an agency specializing in handling such problems. These referral centers are designed to help the individual determine which of a myriad of agencies is most likely

to answer a particular question and to assist in interpreting the procedures for obtaining needed services. The telephone has proved to be the most effective means of communication for these centers because people who are homebound or otherwise unable to come are often able to use a telephone, and they are able to make calls to several agencies from one location. In order to be effective, however, the telephone number of the Center must be widely advertised.

Although radio, television, newspapers and mailings lack the personal touch and it is difficult to obtain feedback from the target group, these mechanisms for communication do reach into the homes of most people and, therefore, are a form of direct contact. They can be used to some extent to provide information to the aged. Research indicates, however, that low income blacks are less likely to trust information they read in the newspaper than are low income whites. This means that in attempting to reach aged blacks with information it is critical to identify individuals in neighborhoods who are trusted information givers and to work through them.

Publicity materials have been mentioned at several points throughout this paper. When such materials are developed to reach the aged, it is important that they be designed with the typical physical limitations of such individuals in mind. Brochures, posters and other printed material should be easily read and understood. Lettering should be large and clear. There should be a high degree of contrast between the color of the background and the color of the letters. The colors used should be those most easily seen by the aged. Blues and greens should be avoided since they are the colors which fade first for aging eyes. Catchy contemporary vocabulary should be avoided. The vocabulary used should be familiar to the target group. Narrators for advertising spots for television and

radio should be selected for the low tones of their voices since high pitched tones fade first from hearing. They should speak slowly and clearly so that they are easily understood.

For those aged who cannot use traditional print materials because of visual impairments or physical disabilities such as paralysis following a stroke, information is available in a variety of formats.

Among these formats are Braille, large print books and magazines, and talking books which are available as records, tapes or cassettes. The Library of Congress has pioneered the development of an extensive network throughout the United States which provides talking books and the equipment to "read" them free to all qualified users. In South Carolina the Library of Congress collection is available to qualified users through the State Library. Materials of local and regional interest are also recorded and made available to qualified users through the same system. Some libraries which serve the blind and the physically handicapped also provide regularly scheduled radio broadcasts to read the newspaper and other materials to qualified individuals. These materials and services are not available to the functionally illiterate or to poor readers, however. Talking books are recorded at speeds which cannot be played on regular equipment, and radio broadcasts cannot be heard on regular receivers. Other non-print materials must be developed for use by the many aged who are either poor readers or functionally illiterate.

Another poorly served group is the deaf. There are comparatively few materials available to transmit information to the deaf. Lip reading provides only minimal understanding at best, and few of the deaf aged have learned sign language. Because it is often wrongly assumed that the deaf are less disabled than the blind, mechanisms for transmitting information

to them are less developed. Special attention must be given to identifying methods for reaching them with information. It is important to remember, too, that the aged often experience multi-handicaps which present special challenges.

Although much of this paper has been devoted to providing information to the disabled aged, it is clear that the vast majority of the aged function independently in society and can obtain information using the same sources and methods we all use. Even though it would be a mistake to assume that most of the aged need special help in satisfying their information needs, it is important to remember that those who are least able to obtain needed information for themselves may well be those who need the information most. It is important, too, to remember that those who care for the dependent aged in institutions or private homes need information related to that care. In addition to information about services available to the aged in their care, nursing home administrators, family members and others who care for the aged need information about the effects of the aging process so that they are better able to understand the needs of those in their care and so that they are better able to satisfy those needs. Families, particularly, need support and help in satisfying their information needs since they, too, may find themselves isolated from their traditional support systems as they devote themselves full-time to the care of an aged family member.

Finally, all of us as aging adults need more information about the realities of the aging process so that we can better understand and prepare for the changes which are taking place in our own bodies and so that we can plan for our own old age more realistically. Such increased understanding may make us better able to counteract society's negative image of

aging. Then individuals may be able to continue to lead active, meaningful lives throughout their lifetimes. We may also be able to design support services which will improve the lives of the dependent aged both today and in the future. By making such improvements today, we have the opportunity not only to help those who are in need now but ourselves in our own old age.

It is clear that satisfaction of the information needs of the aged requires an extensive investment of time, expertise, and money. It is als clear that without such investments, no program of service which you develop can be effectively implemented.

Table 4–16 Library and Information Needs of the Aged

Type of information	User Subgroup	Purpose to User	Response Speed *	Response Mode	Priority **
Information about and referral to community resources.	The aged. Families of aged. Social agencies.	Survival. Survival. Better planning and referral.	1	Telephone Personal outreach—delivery to aged where they are. Interagency cooperation.	1
Promotion of materials and programs projecting a more positive image of aging.	The aged. The total population.	Psychological survival Discovery of new roles. Fuller life.	5	Reading lists, displays, film programs. Book discussions. Mass media.	1–2
Informal adult education group programs.	The aged. The aged and younger adults.	Personal enrichment. Stimulation. Contact with people of different ages.	5	Programs planned with aged. Utilization of wide community resources. Location where aged are. Transportation for aged to library.	2
Adult basic education Reading, computing, coping skills.	The aged with low educational attainment.	Survival. Personal enrichment.	5	Personal—one-to-one tutoring. Adult, easy-reading material. Nonprint material. Cooperation with schools.	2
Delivery of library materials and reader guidance to shut-in and institutionalized.	The aged who are shut-in at home or in institutions.	Stimulation. Personal enrichment.	5	Delivery by librarian.	1
Retirement information.	The middle-aged.	Preparation for fruitful retirement, creative use of leisure, etc.	5	Liaison with business and industry and labor. Reading programs. Lecture programs. Cooperative planning with universities.	1

Table 4–16 Library and Information Needs of the Aged—Cont.

Type of Information	User Subgroup	Purpose to User	Response Speed	Response Mode	Priority
Material for blind and physically handicapped.	The aged unable to use conventional printed material.	Personal enrichment. Stimulation.	4	Audio-visual media ("talking books", cassettes, large-print books). Delivery to where people are. Transportation to library when feasible.	1
How to work with and care for aged.	Families of the aged. Librarians professionals and non-professionals working with the aged.	Survival. Skills to better serve aged.	5	Reading—discussion programs. Film discussion programs. Cooperation with other agencies.	1
Information on the needs of the aged in housing, income, maintenance, health, etc.	Legislators. Administrators responsible for planning services. The general public.	Planning and supporting services for the aged.	5	Capsulated information. Current awareness services. Displays—reading lists. Use of mass media.	1

* 1 = under 4 hr.
2 = under 1 day.
3 = under 1 week.
4 = under 1 mo.
5 = speed not applicable.
** Scale 1 to 5 with 1 top priority.

Table 4–17 The Aged as Users of Library and Information Services: Priority Scale *

The degree to which needs are unmet	Size of group	Relation to broad social goals of Nation	Method of delivery needed	Present assumption of responsibility		
				National	State.	Local
1 Approximately 2% of aged are presently served by libraries.	20 million (1 in 10 Americans). Most neglected by libraries are those living alone in the community.	3 The percentage and number of aged is rising. White House Conference has been held. The Older American's Act has passed.	Interpretive information (1). Personalized delivery (1).	3 (If Older American Act is funded.)	5 (State libraries do little.)	5 (Most public libraries attach low priority.)

*Scale 1 to 5.
1=Most intense.

ADDENDA

Written testimony received prior to Hearing is on the following pages.

Joe S. Dusenbury, Commissioner
S. C. Vocational Rehabilitation Department
P. O. Box 4945
Columbia, S. C. 29240

A REPORT FROM THE SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

TO THE

GENERAL ASSEMBLY'S STUDY COMMITTEE ON AGING

August 16, 1979

The South Carolina Vocational Rehabilitation Department is an independent State Agency which provides Vocational Rehabilitation services to individuals who have a physical or mental disability which results in a handicap to employment. However, the disability must not be so severely limiting that there is not a reasonable expectation that the individual can benefit in terms of employability.

Many senior citizens in South Carolina have handicaps that qualify them for the services provided by the Department, and many apply for services. Older citizens seek rehabilitation services in order to prepare for employment for a variety of reasons. Some have not prepared themselves for older age and have little or no funds for adverse circumstances. Others often have limited steady incomes, but the amount of income actually needed for basic sustenance is beyond them without additional income earned through work. Many simply enjoy the satisfaction that comes with work. Work provides a certain kind of security and an opportunity for social contact, which fulfills a basic need of many people, including older citizens.

To bring services close to the people and to avoid transportation problems (one of the hardest obstacles for senior citizens to overcome), the Department has fourteen major offices scattered strategically around the State and eight satellite offices. Evaluation facilities, mobile evaluation units, workshops, and institutional programs are also available around the state to help with evaluation, prevocational, vocational and social adjustment training.

The Department attempts to cooperate closely with other State and local agencies in an effort to pool resources and together provide comprehensive services in a timely manner. In an effort to provide these services, we try to work with all other agencies in order to avoid duplication. In many instances, we work with other agencies to round out the total services needed for a client. Agreements, which outline referral procedures and what services can be expected from each other, exist with the State Department of Social Services, the Employment Security Commission, and a number of other agencies.

During FY 1978-79, the Department served 56,823 citizens of which 4,091 were of ages 55 and over. For the year 11,314 citizens were successfully rehabilitated, and were able to engage in remunerative employment and gainful activities as a result of the services provided by the Department. Of that number, 816 were 55 to 64 years of age, and 71 were over age 65.

Since the Vocational Rehabilitation Department works with individuals interested in obtaining employment, many older persons are interested in, and receive, our services. Although the Agency makes an effort to provide these needs to the maximum number of eligible citizens, monetary limitations now imposed prevent the Department from serving as many older citizens as we are professionally trained to serve. Basic services by the Department include:

(1) Comprehensive evaluation services, including medical study and diagnosis.

(2) Medical, surgical-related therapy and hospital care to remove or reduce disability.

(3) Prosthetic devices.

(4) Counseling and guidance in achieving vocational adjustment.

(5) Training, including personal, social and skill training.

(6) Service in comprehensive or specialized rehabilitation facilities including workshop and adjustment centers.

(7) Maintenance and transportation as appropriate during rehabilitation.

(8) Tools, equipment, and licenses for work on a job or in establishing a small business.

(9) Placement on a job and follow-up services.

These services are available, as needed, within our budget limitations to eligible clients. Medical services, maintenance, transportation and training are provided based on economic need. Counseling and guidance and placement are provided to clients regardless of economic conditions.

In summary, because of the many similar difficulties faced by the elderly and the handicapped (regardless of age) the Vocational Rehabilitation Department is most supportive of the work of the Joint Study Committee on Aging. Mutual problems which we urge this Committee to continue to support include those associated with transportation, housing, recreation and leisure, and architectural barriers. Because of the lack or absence of these important areas, many citizens, elderly and handicapped, are forced to endure unnecessary restrictions in their full participation in community life.

Kathleen R. Imholz, President
Senior Action, Inc.
402 East McBee
Greenville, S. C. 29601

SENIOR ACTION INC MS MITCHELL
402 EAST MCBEE
GREENVILLE SC 29601

western union Mailgram

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HONORABLE HYMAN RUBIN<CHAIRMAN STUDY COMMITTEE ON AGEING
404 GRESSETTE BLDG
COLUMBIA SC 29201

WE URGE YOUR SUPPORT OF PRESIDENT CARTER'S PROPOSAL THAT FUNDS BE ALLOCATED TO SUBSIDIZE FUEL COSTS FOR THE ELDERLY, HANDICAPPED AND POOR

KATHLEEN R IMHOLZ
PRESIDENT
SENIOR ACTION INC
402 EAST MC BEE
GREENVILLE SC 29601

1436 EST

MGMCOMP MGM

Submitted for Public Hearing - re: telephone conversation

TO REPLY BY MAILGRAM SEE REVERSE SIDE FOR WESTERN UNION'S TOLL - FREE PHONE NUMBERS

Miss Sarah Folk
1421 Wheeler St.
Newberry, S. C. 29108

1421 Wheeler St.
Newberry, S.C. 29108

Sept. 18, 1979

Senator Hyman Rubin Ch.
Study Com. on Aging
Box 5506
Columbia, S.C. 29250

Dear Senator Rubin,

I am sixty-nine years old and am Co-owner of our home with my sister who is fifty-seven. I can not get any tax relief under the homestead act since it states sole owner.

This is a matter which needs changing. I'm sure the law was passed to help senior citizens but as a senior citizen my tax load has not been helped.

I've talked with Mrs. Hamm our Newberry County Auditor and she says it will not be any extra work to her office.

This should be retroactive to the Homestead act bill but I'll be thankful it get it from here on out - which I hope will be a long time.

The city of Newberry exempts its taxes as the State does so I don't get a tax break there either.

Please bring this matter to the attention of your other members on the committee.

Many thanks —

(Miss) Sarah Folk

Joyce J. Williamson
Route 3, Box 97
Salley, S. C. 29137

Route 3, Box 97
Salley, S. C. 29137
September 19, 1979

The Honorable Hyman Rubin
Chairman, Study Committee on Aging
404 Gressette Building
Columbia, South Carolina 29201

Re: Hearing on Hearing Aids - September 21, 1979

Dear Senator Rubin:

I understand that there will be a hearing on problems with hearing aids, etc. at 10:00 A.M. on September 21. Mrs. Keller H. Bumbardner suggested that we send you copies of correspondence which show serious difficulties that my mother, Sallie T. Johnstone, has had and is having with her hearing aids and the American Hearing Center.

Please accept this case for use in the hearing.

Very truly yours,

Joyce J. Williamson

enclosures:

Sept. 12, 1979	Letter from Laura J. Holladay to S.C. Dept. of Health and Environmental Control
July 31, 1979	Letter from Dept. of Consumer Affairs to Laura J. Holladay
June 23, 1979	(Should have been dated July 23) from DEHEC to Laura J. Holladay
June 29, 1979	Letter from American Hearing Center to Sallie Johnstone
June 8, 1979	Letter from Laura J. Holladay to John H. Young, Jr.
June 7, 1979	Letter from Laura J. Holladay to Dept. of Consumer Affairs
May 27, 1979	Letter from Laura J. Holladay to Dept. of Consumer Affairs

Laura J. Holladay
416 Old Saybrook Dr
Columbia, S. C. 29210

September 12, 1979

Mr. Henry M. Riley, Director
Division of Health Licensing
and
Mr. William C. Wilkins, Chief
Bureau of Health Licensing & Certification
South Carolina Department of Health and Environmental Control
Sims - Aycock Building
2600 Bull Street
Columbia, South Carolina 29201

Re: Sallie T. Johnstone/American Hearing Center/Jo D. Owen

Sirs:

I do not understand why you closed the file on my mother's problems outlined in my letter of May 27, 1979 to the South Carolina Department of Consumer Affairs simply because the receipt was mailed. The problems still exist. I will list them below:

1. A 72 year old woman has a hearing aid less than a year old (still in warranty) that is broken for the fourth time this year - the second time in 60 days. The local representative, Mrs. Jo D. Owen has failed to provide service. Now Mrs. Johnstone is having to buy another unit because the one (still in warranty) purchased from American Hearing Center is not dependable.

2. When the hearing aid was purchased, Mrs. Owen insisted that Mrs. Johnstone leave $20 with her for batteries which were to be sent automatically each month. Even though there is still $11 on deposit, no batteries have been sent since May. This was in violation of South Carolina Code of Laws 40-25-160, Section (2)(c)(1).

3. At the time of the purchase, Mrs. Owen was told that there was no possibility of hearing in the right ear. This was determined by the Hearing and Speach Center and by Dr. James E. Harris of Hattiesburg, Mississippi, who did extensive surgery on her ears in order to restore what hearing she has. Mrs. Owen said that she was a "specialist" too and knew as much as the other specialists. This violated South Carolina Code of Laws 40-25-160, section (2)(c)(5).

4. Mrs. Owen said the hearing aid would restore the hearing in Mrs. Johnstone's right ear. This was a violation of South Carolina Code of Laws 40-25-160 section (2)(c)(11).

5. You told me there was a waiver in the file signed by Mrs. Johnstone which waived something - I'm not sure what.

(a) I am unable to find anything in the Code that permits a waiver of anything relating to hearing aids.

(b) Mrs. Johnstone did not sign a waiver or anything else except the sales slip. If there is a signed waiver in the file, it was signed by someone else. Mrs. Johnstone's other daughter, Mrs. Joyce Williamson, was with her during all negotiations for the hearing aid and she will verify that Mrs. Johnstone did not sign a waiver.

This action was a clear violation of South Carolina Code 40-25-160 Section (2)(c)(3) and possibly a violation of Section (2)(f).

6. Mrs. Owen did not give Mrs. Johnstone a copy of the warranty even though she asked for it at least three times. Each time Mrs. Owen promised to bring it. Mrs. Owen finally said she would put the warranty in the file for her since she (Mrs. Owen) could not remember to give it to her. Until Mrs. Johnstone received it with the receipt that was mailed, she did not have any written instructions on how to operate the hearing aid.

In summary, a 72 year old woman has a hearing aid that's not dependable, can't get service from the local representatives, the seller misrepresented her ability as a "specialist" who was more qualified than the medical doctor who performed surgery. Someone signed Mrs. Johnstone's name to a "waiver" which the code does not specifically authorize. The action, and at times the lack of action by Mrs. Owen is a violation of South Carolina Code 40-25-160 section (2)(g).

We call your attention to a statement you made that this dealer has sent six hearing aids off for repair on the date of Mrs. Johnstone's last visit. They had no "loaners" left. This certainly reflects the quality of the hearing aid and of the local service.

Now that Mrs. Johnstone has to buy another hearing aid from a more reputable dealer, what does she do about the old one that is not dependable? Since the factory and/or dealer apparently cannot, or will not, repair the hearing aid satisfactorily, what will happen in two months when the warranty runs out and it quits working in its usual sixty days? We think it should be replaced or the money refunded.

Please reopen this case and make whatever additional investigation is necessary.

Sincerely,

Laura J. Holladay

cc: Ms. Mary M. Grobusky, S. C. Department of Consumer Affairs
2221 Devine Street
P. O. Box 5757
Columbia, S. C. 29250
(Your Complaint No. 1286-79)
Mr. John H. Young, Jr., President, S. C. Commission of
Hearing Aid Dealers & Fitters

The State of South Carolina
Department of Consumer Affairs
2221 DEVINE STREET
P. O. BOX 5757
COLUMBIA, S. C. 29250

IRVIN D. PARKER
ADMINISTRATOR

COMMISSIONERS
GRADY L. PATTERSON, JR.
CHAIRMAN
ROBERT E. HUDSON
COLUMBIA
EMIL W. WALD
ROCK HILL
ELLEN H. SMITH
SPARTANBURG
W. EARL DOUGLAS
MT. PLEASANT

July 31, 1979

Ms. Laura J. Holladay
416 Old Saybrook Drive
Columbia, South Carolina 29210

RE: Complaint No. 1286-79, American Hearing Center

Dear Ms. Holladay:

We are in receipt of a letter that the Department of Health and Environmental Control sent you in response to your complaint against the American Hearing Center. I hope this information was helpful to you.

As I understand, it was determined that Mrs. Jo D. Owen was in violation of Section 201.1 H of the Rules and Regulations to Regulate the Practice of Selling and Fitting Hearing Aids within the State of South Carolina. It is stated that a receipt has been mailed to your mother. Therefore, it is our understanding that your complaint has now been resolved to your satisfaction. Accordingly, we are closing your file with this letter.

However, if you require any further information or assistance with this complaint or a complaint in the future, please do not hesitate to contact us again.

Sincerely yours,

Mary M. Grobusky
Consumer Complaint Analyst

MMG:nmk
cc:American Hearing Center
William C. Wilkins, DHEC

TELEPHONES (AREA CODE 803)

ADMINISTRATION	CONSUMER COMPLAINTS	CONSUMER EDUCATION	NOTIFICATION	ENFORCEMENT
758-3017	758-2040	758-7546	758-8587	758-5864

WATTS 1-800-922-1594

BOARD
William M. Wilson, Chairman
William C. Moore, Jr., D.M.D., Vice-Chairman
I. DeQuincey Newman, Secretary
Leonard W. Douglas, M.D.
George G. Graham, D.D.S.
J. Lorin Mason, Jr., M.D.
C. Maurice Patterson

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Albert G. Randall, M.D., M.P.H.
Commissioner

Sims Aycock Buildings
2600 Bull Street, Columbia, SC 29201

Rec'd July 23

June 23, 1979

Mrs. Laura Holladay
416 Old Saybrook Drive
Columbia, South Carolina 29210

Dear Mrs. Holladay:

As discussed with you by Mr. Wicker of this Department on July 17, 1979, the American Hearing Center was visited on June 27, 1979, for the purpose of investigating the complaints stated in your letter of May 27, 1979, to the South Carolina Department of Consumer Affairs.

As a result of this visit it was determined that Mrs. Jo D. Owen was in violation of Section 201.1(h) of the Rules and Regulations to Regulate the Practice of Selling and Fitting Hearing Aids within the State of South Carolina; however, it is our understanding that a receipt has been mailed to your mother.

Mrs. Holladay, your bringing this item to our attention is appreciated and we will continue to make unannounced visits to hearing aid dealers in our State to ensure that they are meeting the requirements of the Rules and Regulations for Hearing Aid Dealers.

Sincerely,

Henry M. Riley, Jr. (mp)
Henry M. Riley, Jr., Director
Division of Health Licensing

William C. Wilkins/jm
William C. Wilkins, Chief
Bureau of Health Licensing & Certification

HMR:WJW:jm

cc: Mr. John H. Young, Jr., President, S. C. Commission of Hearing Aid Dealers & Fitters
Mrs. Jo D. Owen, American Hearing Center
Ms. Mary M. Grobusky, S. C. Department of Consumer Affairs

AMERICAN HEARING CENTER
5301 Two Notch Road
P. O. Box 4743
COLUMBIA, SOUTH CAROLINA 29240
Telephone 786-2174

JUNE 29, 1979

MRS SALLIE JOHNSTONE
127 RAELNER STREET
WEST COLUMBIA, S.C.

DEAR MRS JOHNSTONE'

WE ARE ENCLOSING A COPY OF THE SALES CONTRACT, FOR YOUR HEARING AID, DATED OCTOBER 11, 1978.

WE ARE ALSO ENCLOSING ANOTHER BOOKLET ENTITLED 'WELCOME TO THE WORLD OF SOUND' THE WARRANTY IS WRITTEN ON THE LAST PAGE OF THE BOOKLET. THE REASON FOR THE DIFFERENT DATE AND SERIAL NO. ON THE BACK COVER IS THAT THIS IS THE BOOKLET THAT CAME WITH THE AID YOU DID NOT WISH TO KEEP.

SINCERELY,
Edna A. Roberts

CUSTOMER'S PURCHASE CONTRACT

American Hearing Center
5301 Two Notch Road
P. O. Box 4743
Columbia, S. C. 29240
Phone (803) 786-2174
License No. 119

Date _____

Office _____

BUYER agrees to purchase from the above Seller a new Hearing Aid and/or Equipment as follows:

MAKE	MODEL	SERIAL NUMBER	RECEIVERS		RECEIVER CORDS	HEADBANDS	BATTERIES	ACCESSORIES
			AIR	BONE				

PURCHASE PRICE ..... $_____

SALES TAX ..... $_____

TOTAL ..... $_____

PAYMENT W/ORDER ..... $_____

BALANCE DUE ON DELIVERY ..... $_____

You may cancel this transaction, without any penalty or obligation, at any time prior to midnight of the third day after the date of this transaction. See the attached Notice of Cancellation form for an explanation of this right.

This contract must be signed in ink.

Executed in Duplicate

this _____ day of _____, 19____

in the presence of:

(Witness) _____

Countersigned _____

Customer's Signature: (Mr.) (Mrs.) (Ms.) _____

Customer's Full Name (Print) _____

Home Address _____

City, County & State: _____

Business Address _____

City, County & State: _____

ACCEPTED BY SELLER: By: _____

The Battery Club has been explained to me. I wish to become a member of the Battery Club.

I am enclosing ten dollars ($10.00) which will be applied toward the purchase of batteries.

Signature _____

416 Old Saybrook Drive
Columbia, South Carolina 29210
June 8, 1979

Mr. John H. Young, Jr.
1607 Brabham Avenue
Columbia, South Carolina

Re: Sallie T. Johnstone

Dear Mr. Young:

I am enclosing copies of correspondence between myself and the Consumer Affairs Department in reference to my Mother's hearing aid purchase and subsequent problems. I do not know if they can help, but seriously doubt it.

We do appreciate your seeing her and helping to get her aid fixed. My sister told me you would see that this complaint reached the proper office in DEHEC. There are so many departments I'm afraid it I mail it, it would be weeks or months before the proper person received it.

It upsets us so much to see how advantages are taken of older folks day to day and they just don't realize that they have anyone they can complain to. We do appreciate your help in this matter.

Sincerely yours,

Laura J. Holladay

Enclosures

416 Old Saybrook Drive
Columbia, South Carolina 29210
June 7, 1979

Department of Consumer Affairs
State of South Carolina
P. O. Box 5757
Columbia, South Carolina 29250

Attention: Thalia A. Farley
Consumer Complaint Analyst

Re: Complaint #1286-79
Your Letter of June 1, 1979

Gentlemen:

Enclosed are copies of my Mother's cancelled checks, she was not given a sales slip or bill of sale. Also, she asked Ms. Owen for her warranty when she bought the aid and was told that she would mail it to her. She had not received it when the hearing aid broke in December and when Ms. Owen brought it back to her, mother asked about the warranty again. Ms. Owen told her she forgot it, but just so mother would not lose it, she would keep it in her file in her office. So she never received one, which makes us question the business practice of this firm even more. Ms. Owen told mother her old hearing aid could not be fixed, but they would take it in trade - "they might be able to use a part off of it." So the price, $150.00 plus $102.00, is with a "trade-in".

If you need anything further, please let me know.

Very truly yours,

Laura J. Holladay

Enclosures

MRS SALLIE JOHNSTONE

No.

Oct 11 19 78

67-22
532

PAY TO THE ORDER OF American Hearing Center $ 150.00

One Hundred fifty and No/100 DOLLARS

THE SOUTH CAROLINA NATIONAL BANK
COLUMBIA, S. C.

Sallie Johnstone

⑆053200222⑆ ⑈32⑈2 0 9687 6⑈ ⑈00000150000⑈

MRS SALLIE JOHNSTONE

No.

Nov 13 19 78

67-22
532

PAY TO THE ORDER OF American Hearing Center $ 162.00

One Hundred Sixty two and No/100 DOLLARS

THE SOUTH CAROLINA NATIONAL BANK
COLUMBIA, S. C.

Sallie Johnstone

⑆053200222⑆ ⑈32⑈2 0 9687 6⑈ ⑈00000162000⑈

416 Old Saybrook Drive
Columbia, South Carolina 29210
May 27, 1979

Department of Consumer Affairs
State of South Carolina
P. O. Box 5757
Columbia, South Carolina 29250

Re: Jo D. Owen, Hearing Consultant
American Hearing Center

Gentlemen:

I have a most unjustified situation, but I'm not sure you can help. It appears that the people most affected by this type of business are the very ones who can least afford it - the elderly living on small fixed incomes.

My Mother, Sallie Johnstone, is 71 years old. She has only 33% hearing in one ear with aid, and none in the other ear - verified and tested by the S. C. Hearing and Speech Center. She has had to buy a new hearing aid on the average of one every 24 months, which seems utterly ridiculous, at a cost of $300+, a major investment for her. They are warranted for one year, and when they've lasted beyond that, she has been told it cost more to repair than a new one would cost.

Her last hearing aid was purchased from the above firm in October, 1978, at a cost of $312.00. Three months after she got it, it went dead; new batteries did not help. The consultant listed above, who sold the device to her, loaned her one to use and returned the new one to the factory for repair. At the time the aid returned from the factory, the consultant suggested that Mother should get another hearing aid for her other ear, and that she felt sure it would help tremendously. Upon hearing of this, my sister and I took her to the S. C. Hearing Center to have her hearing tested by someone not selling hearing aids. She was told that she had absolutely no hearing in the ear that the consultant wanted to fit a device for, and only 33% in the other ear with a hearing aid. She told the above consultant this information when Ms Owen visited her at home and Ms. Owen told her that, she too was a specialist, and that she believed a hearing aid in that ear would help. Also, that she was going ahead and make a mold, from an impression made then and there, at my Mother's house, at her own expense, and wanted Mother to wear it for ten days to see.

This upset us at no end since we felt an advantage was being taken since sometimes a sense of balance, phonics, echo or whatever, can give you a feeling of hearing better, when we knew in fact, she had no hearing left in that ear. We tried numerous times to call Ms Owen, but she was always out of town or not in today, etc. Ms Owen visited Mother several weeks ago and brought the new hearing aid for her to try - which she did. At first, she felt she could indeed hear better. Then one day she had the device out and it began a high pitched sound which she heard with her good ear. She listened with the other ear, and moved the humming device from one ear to the other and realized that she could not hear with the bad ear and that it actually hurt from the pitch, her good ear. This was what made her

decide to return the aid when Ms Owen came back in 10 days to check. Ms Owen said she was sorry, she had felt sure the device would help.

Several weeks later, Mother's hearing aid of only six months, went dead for the second time, and new batteries did not help. An appointment was made personally with Ms Owen for 9:00 a.m., Wednesday, May 9th, at the office of the above center on Two Notch Road. Upon arrival Mother was told that Ms Owen could not make it today. Ms Owen had not tried to reach us to let us know she would not be there, even though she had the phone number of both Mother and my sister.

The man in the hearing center said he could not work on it, that it most probably had wax down deep inside and would have to be sent back to the factory. He was sorry but they did not have any they could lend her to use until it was returned. She had been without a hearing device for almost a week at that point and it is almost impossible to carry on a conversation without one. She was expected to wait another three or four weeks without any aid while they sent hers back to the factory for cleaning. They had provided one for her use in the past when it had to be returned but now they did not have one (since she did not buy the additional device for her other ear, or so it seemed.) The appointment was not kept, no attempt made to notify anyone and my sister was spending the night with my Mother since she was alone and without a hearing aid.

Still unable to contact Ms Owen, we called another hearing specialist (Mr. Jack Young) who agreed to return her aid to the factory (he does not represent the company that made the device.) and also loaned her one to use until hers could be repaired. A week or so later, Mr. Young received a call from the factory; from someone very ugly and quite rude, asking him if he was handling that particular brand now. He explained the situation to them. Several days later the hearing aid came back.

As you can see, this has been quite disturbing. A new, major purchase, only six months old, already having to be returned to the factory twice. Unable to get a loaner from the franchised people the aid was bought from. A consultant insisting she was a specialist and could fit Mother with an aid for her deaf ear; and now, unable to get service on her new aid and unable to buy another aid at this time since it takes a year or two to save enough to buy one at the rate they seem to "wear" out.

It is our opinion that the above practice is a questionable operation. I have talked with numerous people who have aids, and the specialist at the hearing and speech center and everyone confirms the fact that a hearing device should last longer than a year or two, and usually up to 6 and 7 years; and, that reputable dealers, specialists, etc., stand behind their product and provide service for them.

We feel despair and at the same time, anger and feel that someone, this kind of advantage and injustice of this elderly should be brought under control if possible. We would prefer to have the money refunded so that she can purchase a hearing aid from someone who will service it for her. We do not know if any law was broken, but feel certainly that an unfair advantage has been taken at the least.

We would appreciate any help you can give us in this matter.

Yours very truly,

Laura J. Holliday

Deloris N. Zeigler, R.N., M.N.
Chief, Bureau of Chronic Disease
and Home Health Care
S. C. Department of Health and
Environmental Control
2600 Bull St.
Columbia, S. C. 29201

I appreciate the opportunity to submit written testimony to the FY 80 Study Committee on Aging. My remarks will be confined to DHEC's Home Health Services concerns.

We are appreciative of the fine support of the Study Committee on Aging which lead to restoration of the 5% ($35,000) budgetary cut in FY 80 and of the $155,000, thirty percent match for Title XX Health Support/Homemaker Service in FY 79.

I will speak to recommendations of seven points which are directly related to the provision of Home Health Services.

I. Amending the South Carolina Medicaid Plan to Provide Medicaid Coverage for the Medically Indigent

This would allow 75% federal financing thereby utilizing current HHS state appropriation to match the federal dollars. The end result would be increased population coverage.

II. Legislation Regarding Mandatory Coverage of Home Health Services in Basic Health Insurance Plans

The bias toward hospitalization and institutionalization excluding home health benefits by some private insurance companies leaves a significant number of persons without coverage. The 55 to 65 year age groups are especially affected.

III. Additional State Appropriation for Home Health Services in FY 81 to Increase Services to the Medically Indigent (If Item I is supported it would reduce the need for this.)

There is a critical need for funds to serve medically indigent patients who have no source for payment. In FY 79, 1,091 such patients requested services and could not be admitted. Private agencies providing home health services in South Carolina generally accept only patients who can afford to pay their charges. This situation is causing an increasing number of the medically indigent patients to seek services from DHEC. The annual cost per patient is approximately $510 for an average of 17 visits. The additional funds requested will enable the Department to serve these patients.

IV. Certificate of Need Amendment to South Carolina Legislation - Licensure of Home Health Agencies.

The provision for certificate of need, deleted in the drafted legislation, provides for orderly growth of home health agencies thereby reducing the proliferation of Home Health Agencies and related difficulties experienced in Florida.

V. Support Flexibility in the Use of Title XX Matching Funds.

In the event that FY 80 Title XX contract for Health Support/Homemaker is not signed, support DHEC's use of the $155,000 match to finance these services to the medically indigent.

VI. Alternative to Institutionalization Project.

We offer strong support to appropriate funding of the Alternatives to Institutionalization Project in Appalachia II.

VII. Relief from Insufficient Reimbursement of Caregiver Travel Costs by Prioritizing Designation of State Vehicles or Other Alternatives

Caregiver employees in the lower state merit classifications (i.e., home health aides) are adversely affected by the 18¢ per mile travel reimbursement in relation to the high cost of gasoline. Giving priority to assigning state vehicles to these employees would address the problem.

A second solution would be issuance of credit cards to these personnel.

A third alternative which could provide a measure of relief would be more timely and/or more frequent payment of travel claims.

These concerns are based on our efforts to fill some of the gaps in home health care.

Deloris N. Zeigler

Deloris N. Zeigler, R.N., M.N.
Chief, Bureau of Chronic Disease and
Home Health Care

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